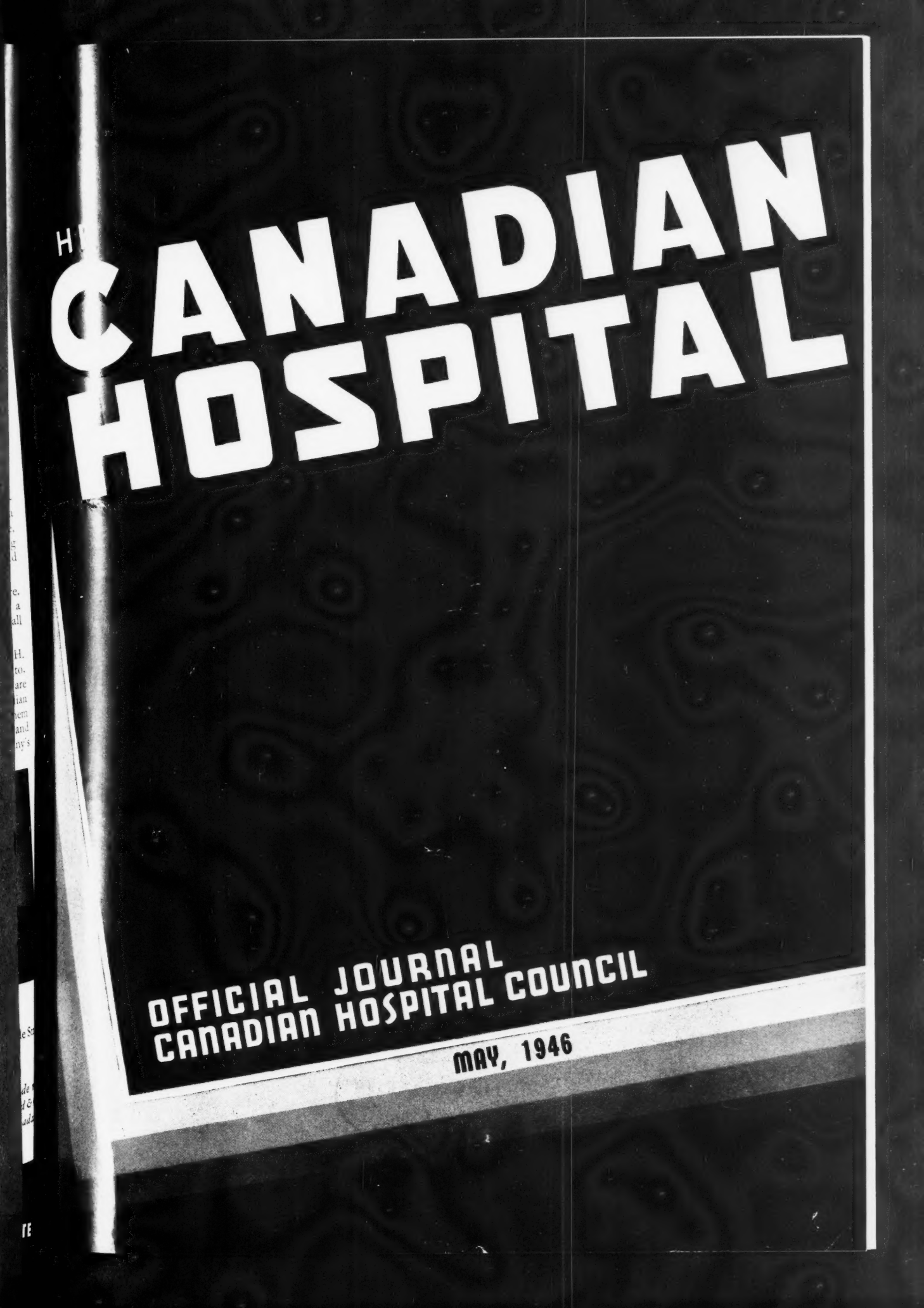
CANADIAN
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OFFICIAL JOURNAL
CANADIAN HOSPITAL COUNCIL
MAY, 1946

Give Your Laundry Department...

A FIGHTING CHANCE!

WITH EVERY room, every ward bed occupied, and a long list waiting, your laundry department is of topmost importance. Is it helping or dragging back?

Every department in the hospital depends on the laundry. Yet it is often one of the most neglected departments, sometimes limping along with ancient machinery, a constant threat to hospital efficiency. Keen-minded top executives who give it a minute's thought, will see how vitally important it is to *give the laundry a fighting chance.*

Why not *find out* how improved methods, machines and equipment, can cut laundry costs way down, lengthen life and wearing quality of hospital linens? Why not make sure your hospital will always have an uninterrupted flow of snowy sterile sheets, spreads, towels, bedding, uniforms?

It's easy to get the facts. Ask NOW, for our Laundry Advisor, to analyze YOUR particular hospital's laundry condition. He can show you how to boost efficiency WAY UP, in your laundry department.

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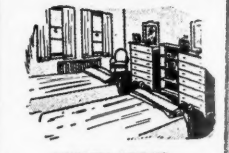
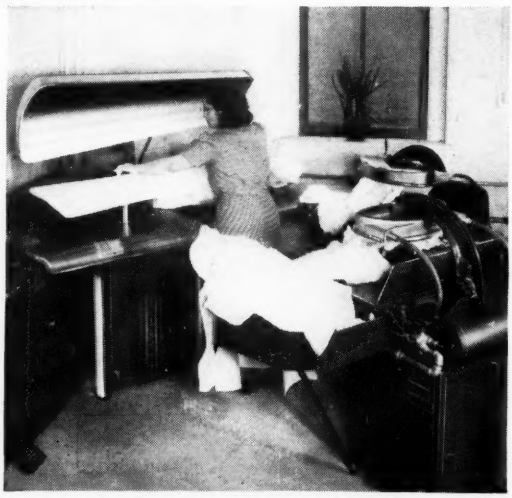


NURSES' ROOMS



The highly efficient NURSES' UNIFORM Press Unit means smart staff appearance, lower finishing costs.

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Supplementing its line of bobbin-wound catgut sutures, Davis & Geck offers a new line of Cotton, Surgilon and Anacap Silk Sutures ready-wound on plastic bobbins. Packaged in unsterilized (dry) condition in boxes of ten, these bobbins fit either the Singer or the Vim-Ogburn types of surgical stitching instruments.

Bobbin-wound sutures eliminate the tedious task of winding sutures manually for use with surgical stitching instruments. A sterilized needle is simply clamped into position, the surgical stitching instrument threaded, and it is then ready for use. The plastic bobbins are chemically inert and dimensionally stable, and thus may be readily sterilized by boiling in water or by pressure sterilization.

Here is further evidence that D&G is constantly advancing new improvements in surgical equipment to meet increasingly exacting demands for service in sutures.

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D & G sutures are obtainable through responsible dealers everywhere

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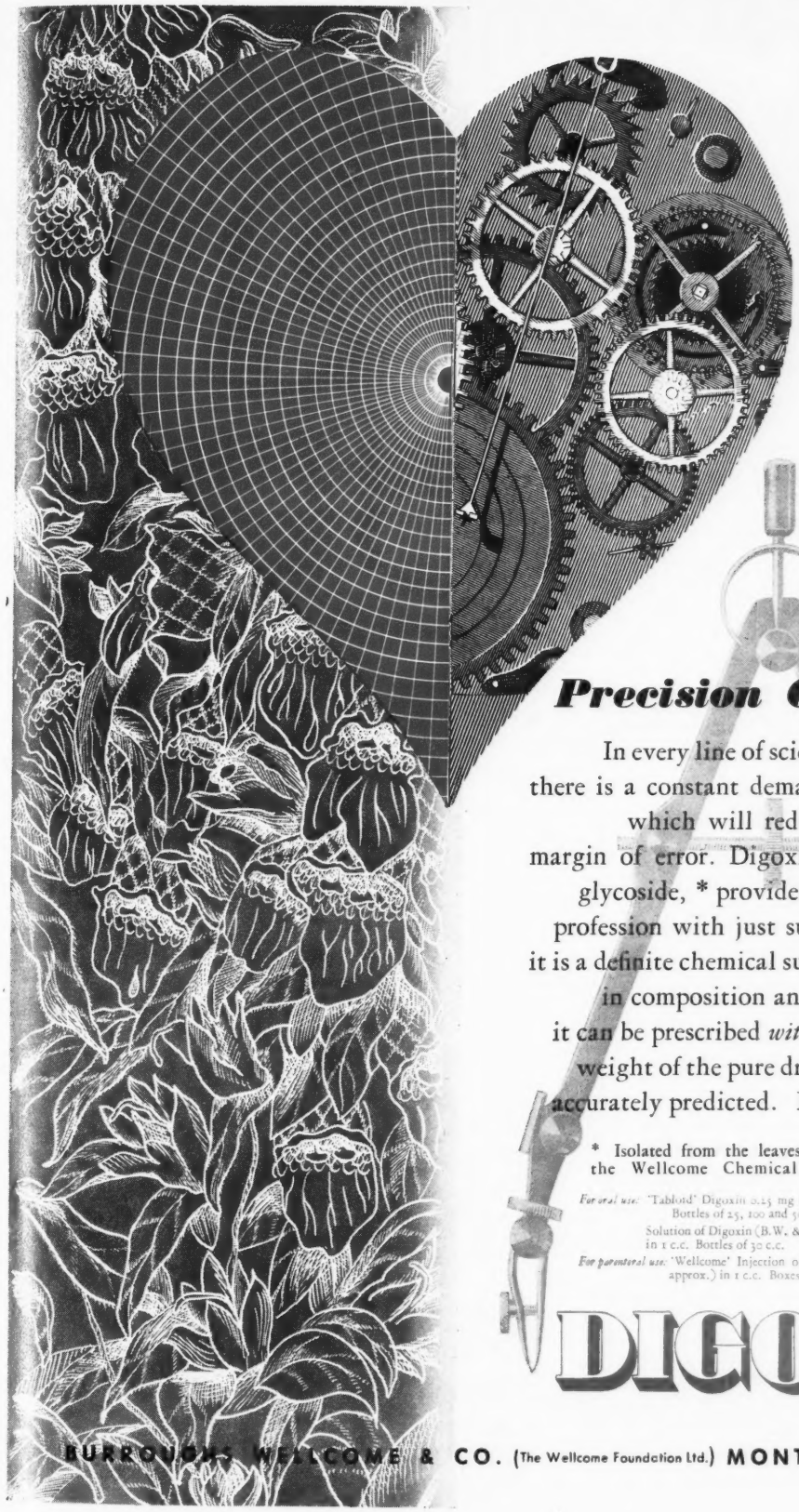
Contents

Vol. 23 **MAY, 1946** No. 5



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In every line of scientific endeavour there is a constant demand for any device which will reduce or eliminate the margin of error. Digoxin, a pure crystalline glycoside, * provides the medical profession with just such an aid. Because it is a definite chemical substance, constant in composition and uniform in potency, it can be prescribed *with precision* in terms of weight of the pure drug, and its results accurately predicted. Literature on request.

* Isolated from the leaves of digitalis lanata by the Wellcome Chemical Works (England).

For oral use: 'Tablond' Digoxin 0.25 mg (gr. 1/260 approx.) Bottles of 25, 100 and 500.
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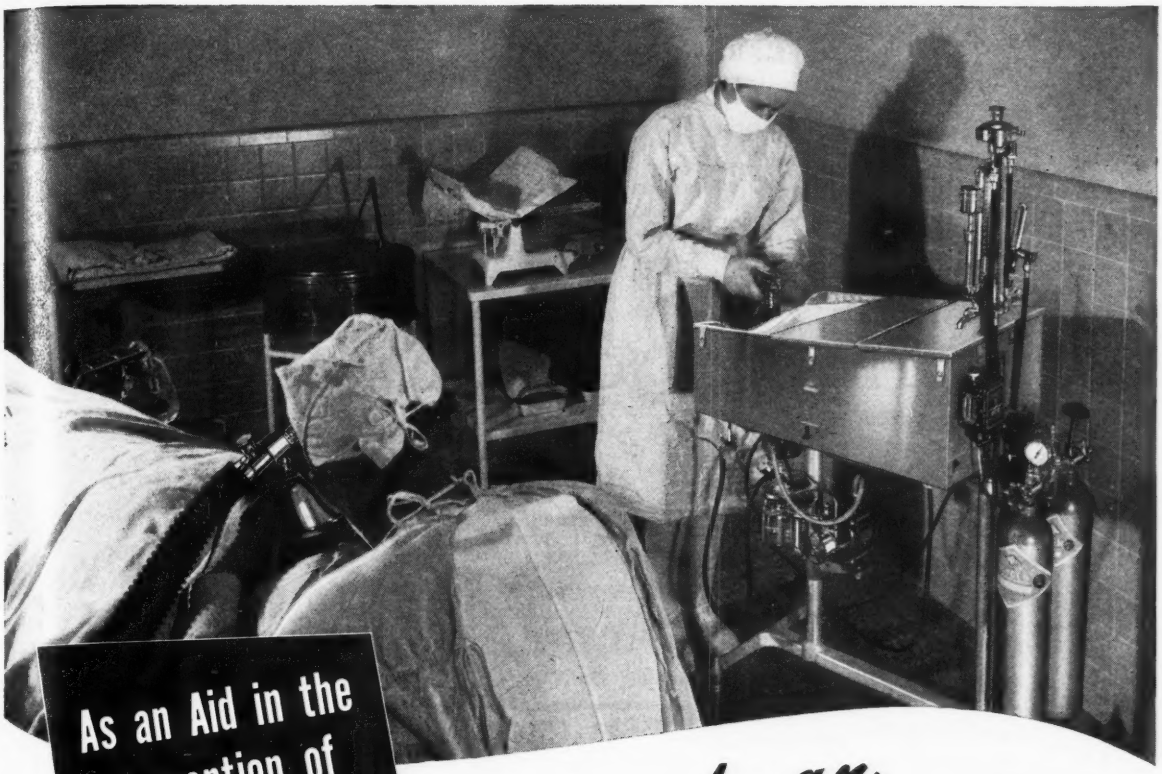

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FOR many years Kreiselman Resuscitators have been used by leading hospitals and prominent physicians and have been proved correct in principle, efficient and simple to operate, and durable.

These resuscitators operate on a positive pressure principle and with pre-selected pressures ranging from 2 to 25 mm. mercury. (On infant models pressures range from 2 to 15 mm. mercury.) The model illustrated above is a combined resuscitator and heated bassinet thermostatically controlled. The heat is always constant and correct.

Included in the Kreiselman line are machines for adults and infants—heated bassinet models and bassinets with head tents.

An informative 20-page booklet just published gives complete details about Kreiselman Resuscitators. This booklet will be supplied upon request, together with a copy of the reprinted article "The Treatment of Asphyxia" by Joseph Kreiselman, M.D., Consultant in Anesthesiology, George Washington University Medical School.

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ANTISEPSIS

In rare conditions and everyday practice

'The successful use of intrapleural lavage in a case of pyrothorax and bronchial 'fistula was described by Gilmour in 1937. The chosen antiseptic was Dettol which 'was used first in a concentration of 1 in 20 and later at full strength. At the end of 'each washout 20 c.c. of pure Dettol was left in the pleural cavity. Some of this was 'coughed up via the fistula, and some swallowed with no ill effect. The treatment was 'continued for 7 weeks, at the end of which the pleural space was obliterating, the fluid 'serous, and the patient's general condition very satisfactory. Recovery was uneventful.'*

** Santon Gilmour. (1937) Tubercle, vol. 19, p. 105.*

A rare case — admittedly, yet not without some bearing on problems in everyday practice.

For what can reasonably be concluded about the attributes of an antiseptic that could be so used, for so long, and with such a result ? Obviously it must have been highly bactericidal ; it must have been non-toxic, even at full strength and even on prolonged contact with the pleura and the gastro - intestinal mucous membrane ; it must also have been non-irritant and non-corrosive, for otherwise it would have increased the

vulnerability of the tissues to the infection and inhibited the natural processes of healing.

And in fact the clinical experience of over 12 years, in all the contingencies of practice that call for rapid, effective and safe antisepsis, has shown that 'Dettol' does combine, in high measure, these fundamental attributes of an antiseptic for general use in medicine, surgery and obstetrics.

'DETTOL' OBSTETRIC CREAM

— a non-toxic highly bactericidal preparation sharing all the essential attributes of 'Dettol' but with its own special place in obstetric practice.

Originally tested at Queen Charlotte's Hospital, London, in 1932, 'Dettol' Obstetric Cream is now in general use in maternity hospitals in Great Britain and throughout the Empire.

Rapidly lethal to hæmolytic streptococci

First, because of the antiseptic itself. 'Dettol' rapidly destroys — among other pathogenic organisms—the hæmolytic streptococci responsible for most puerperal infections. It was this particular quality that lead to its adoption as the routine antiseptic in London's great maternity hospital, Queen Charlotte's.

A persistent barrier to re-infection

Secondly, because of the concentration. Applied to the skin 'Dettol' 30 per cent. not only destroys hæmolytic streptococci, but forms a barrier to re-infection which lasts over two hours. In grossly contaminated cases it would naturally be applied at shorter intervals; but in routine practice two-hourly applications are more than adequate.

Intimate contact with skin and mucous membranes

Thirdly, because of the vehicle. The pleasant creamy preparation remains in contact with the surface over which it is smeared. The continuity of the barrier to re-infection is thus assured.

Some clinical applications

Possessing these special attributes, 'Dettol' Obstetric Cream is used by doctors and nurses in nearly every maternity hospital of the British Empire for the sterilization of the gloved hands and for their rapid re-sterilization during the conduct of labour. It is applied as a routine to the patient's vulva, perineum and thighs, and smeared periodically over the patient's hands.

The introduction of 'Dettol' Cream into the obstetric routine at Queen Charlotte's Hospital was immediately followed by a 50 per cent. decline (by comparison with the period immediately preceeding) in the incidence of puerperal infection.

RECKITT & COLMAN (CANADA) LIMITED, PHARMACEUTICAL DIVISION, MONTREAL

MIIA

Across the Desk

By C. A. P.

Advancement of Pharmacy

THE Canadian Foundation for the Advancement of Pharmacy has raised $46,120.00 since its inception in September of last year, J. P. Kennedy, President, announced a short time ago. These funds have been subscribed by fifty-nine contributors, the majority of whom are manufacturers of drugs, pharmaceuticals and toilet goods, wholesale drug companies and those engaged in allied trades.

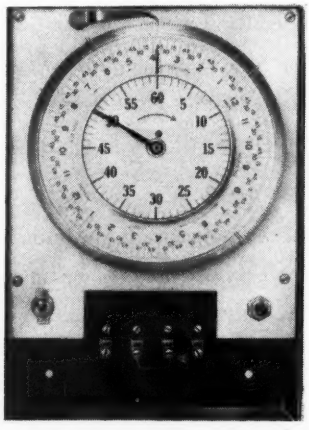
At a directors' meeting held in Toronto, a maximum of ten thousand dollars was placed at the disposal of the committee on grants to implement the Foundation's educational programme for the fiscal year 1946-1947. This programme includes scholarships, teaching fellowships, graduate fellowships, graduate assistantships and research in pharmacy.

The committee on extension services is presently preparing their recommendations for assisting provincial associations in making available refresher courses to retail druggists so that those now directly engaged in pharmacy may obtain the latest information and knowledge regarding new drugs and prescription procedure.

* * * *

New Electric Program Time Switch

A new simplified automatic control of radio and recorded programs has been perfected by Zenith Electric Company, Chicago, Ill. The unit is now available to the market.



This control is embodied in a Zenith Program Time Switch Type PR-24, which operates automatically to periods as close as five minutes throughout the twenty-four hours, or any part thereof. It repeats daily, requiring no further attention than the setting. Changes in the setting are easily and quickly made without tools, by anyone.

The unit is a marked time-saver for institutions where radio or recorded programs are a daily feature. It can be used to cover any radio or recorded program, or range of programs. The Zenith control turns on and off the stations or records exactly as pre-determined. It embodies the well known Zenith Program Timer, and special relays, assuring accuracy within two seconds.

(Continued on page 16)

Across The Desk

Retirement of Col. Sharman

Retirement of Col. C. H. L. Sharman, C.M.G., C.B.E., of Ottawa, after 48 years in government service, was announced recently by the Hon. Brooke Claxton, minister of National Health and Welfare.

Since 1927 Col. Sharman has been chief of the narcotic division of this department, K. C. Hossick, assistant head of the division since 1928, has been named acting chief.

In 1931 and 1936 Col. Sharman was one of Canada's delegates in negotiating international agreements relating to narcotics and since 1934 has been Canadian representative on the League of Nations' advisory committee on the traffic in opium and other dangerous drugs. Arrangements have been made for him to represent Canada on the narcotic drug commission established under the Economic and Social Council of the United Nations.

* * * *

Extra Rations for Doctors' Patients

For the benefit of those doctors who wish to obtain extra rations for their patients, the Wartime Prices and Trade Board has issued a reminder that the doctor's statement to the Board must contain the following information; name and address of the applicant, name of the disease, kind and amount of rationed food required over and above the regular ration, the length of time these extra rationed foods will be necessary and the age of the patient, if under sixteen.

The Ration Administration has experienced considerable difficulty in complying with the doctors' requests for extra rations when complete information as to their patient's requirements has not been given. For example, a doctor will write in to the Ration Office saying that Mrs. Jones needs extra sugar because she has a certain ailment, but there is no indication as to how long the patient needs the extra sugar or how much she needs.

* * * *

The Low Cost of Advertising

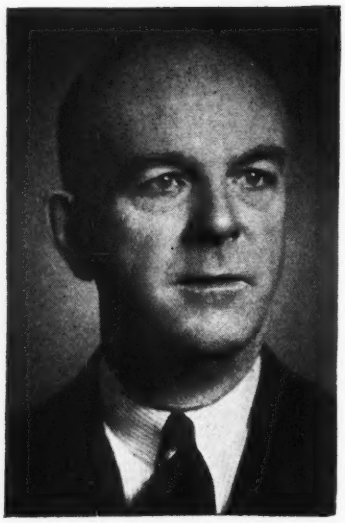
Critics of advertising have developed an apparently incurable habit of quoting the annual expenditures of large national advertisers and exclaiming at the "extravagant spending". Their contention is that the consumer pays for these millions, thus accounting largely for the high cost of living.

In its annual report, the American Tobacco Company, manufacturer of Lucky Strike cigarettes, points out that the impression of extravagant spending is contrary to fact. The advertising expense for Lucky Strike in magazines, newspapers and radio time amounts to only 12.7 cents per thousand cigarettes, stockholders are assured.

The figure works out at 1.2 cents per hundred carton and, assuming that sales held up if all advertising were discontinued, the saving would be so infinitesimal that it could not be passed on to the consumer.

—*Marketing.*

(Concluded on page 20)



Johnson & Johnson Executive Appointments

W. M. Campbell, Vice-President of Johnson & Johnson Limited, has announced the appointments of J. C. Nelles, Director of the Hospital Division, and J. A. Grier, Director of the Professional Division.

Mr. Nelles has been on the staff of Johnson & Johnson for the past nine years, serving in various executive capacities.

Mr. Grier served as Deputy Administrator of Pharmaceuticals, Wartime Prices & Trade Board, prior to joining Johnson & Johnson last year.

J. C. Nelles **J. A. Grier**

Orchids to the Editor!

We have just received a batch of clippings of items published in Canadian daily newspapers which reviewed or reprinted articles and editorials previously published in The Canadian Hospital.

This department is pleased to note the increasing use by the daily press of material prepared for our readers, which reflects very definitely the prestige and authoritative standing of our journal in the hospital field.

Adaptable

A stout gentleman, determined to lose weight during a stay on his Vermont farm, picked out a big pair of overalls for energetic exercise. Then a thought struck him. "Wait a minute," he said to the clerk, "those fit me now, but I expect to lose a lot—maybe I had better buy a smaller pair."

The clerk shook his head, calmly went on wrapping the overalls. "Mister, if you can shrink as fast as those overalls will you'll be doing pretty good."

The following are expert designers and fabricators of "Monel" food service equipment:

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General Steel Wares Limited
Montreal, London, Calgary
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Canadian Rogers Sheet Metal & Roofing Limited
Winnipeg, Man., Toronto, Ont.

The Macdonald Bros. Sheet Metal & Roofing Co. Limited
Winnipeg, Man.

Ellett Copper & Brass Co. Limited
Vancouver, B. C.

Quest Metal Works Limited
Vancouver, B. C.

Terminal Sheet Metal Works Limited
Vancouver, B. C.

The International Nickel Company of Canada, Limited
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Please send me a copy of the booklet F-51, "Everywhere on the Continent—#35 Monel Food Service Equipment".

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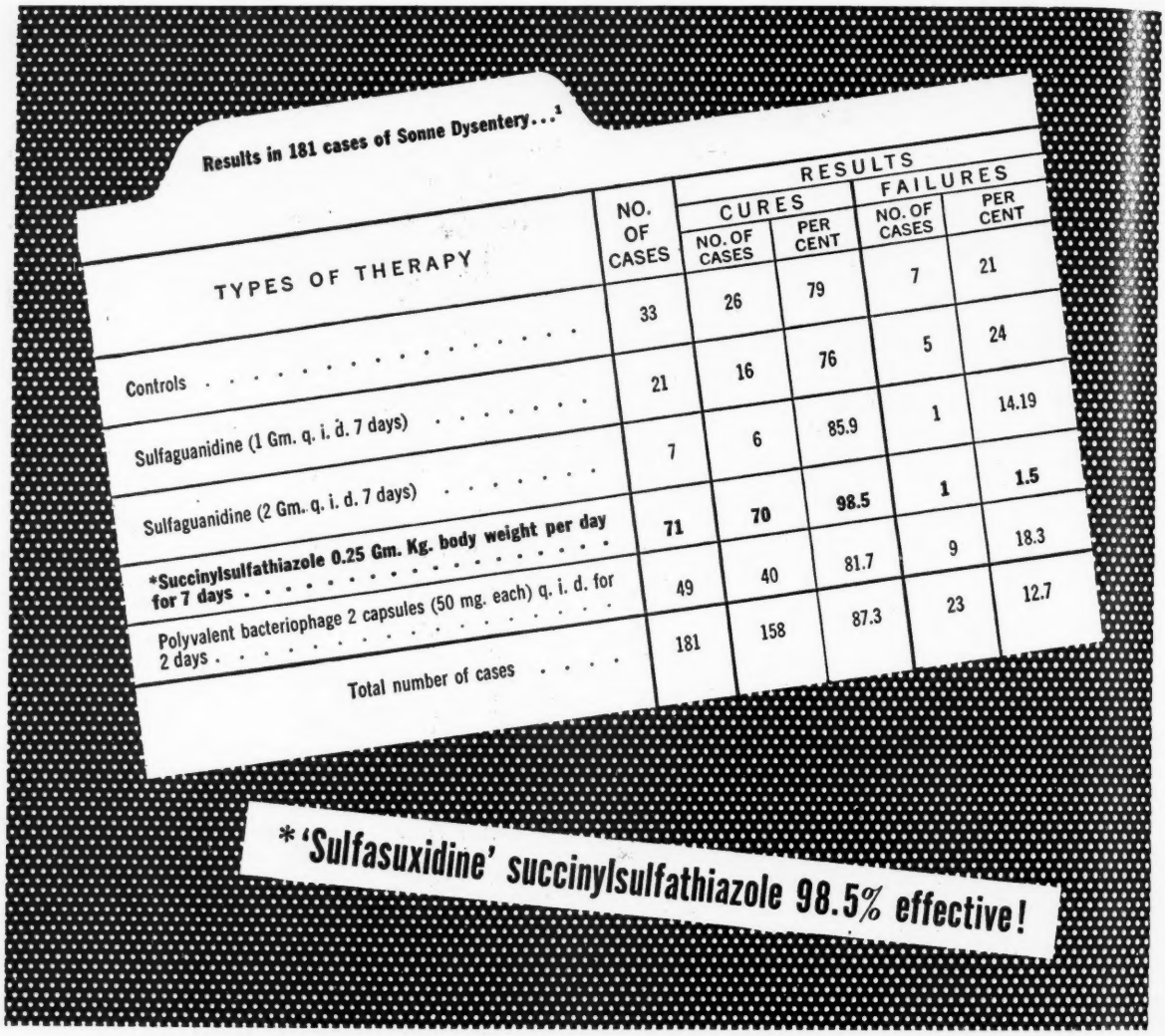

'SULFASUXIDINE' *succinylsulfathiazole* recently demonstrated its therapeutic superiority, convincingly and impressively, when an outbreak of Sonne dysentery struck a basic training center of the Army Air Forces.

Administered to 71 patients, 'SULFASUXIDINE' *succinylsulfathiazole* was effective in 70 of these men, or 98.5%[1]. Blood levels averaged 0.22 mg. per 100 cc.

Service physicians then concluded "Succinylsulfathiazole 0.25 Gm. per kilogram daily for seven days was efficacious in the eradication of the carrier state."[1]

In addition to its use in acute or chronic bacillary dysentery as well as the carrier state, the compound is effective in ulcerative colitis and is a drug of choice for bacteriostasis, with particular reference to gram-negative organisms, in intestinal surgery.

'SULFASUXIDINE' *succinylsulfathiazole* is supplied in 0.5-Gm. tablets in bottles of 100, 500 and 1,000, as well as in powder form (for oral administration) in ¼ and 1-pound bottles. Sharp & Dohme (Canada), Ltd., Toronto 5, Ontario.

1. J. A. M. A. *128*:1152-1155, August 18, 1945.

'SULFASUXIDINE' *Succinylsulfathiazole* SHARP & DOHME

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First...

and most essential, this widely employed medium combines both germicidal and sporicidal potency. Unexcelled for use with precision steel instruments and keen cutting edges. Knife blades covered with a dried blood contamination of *Staph. aureus* are consistently disinfected within 2 minutes. Within 1 hour the spores of *B. anthracis*, and within 4 hours the spores of *Cl. welchii* are destroyed. Even the extremely resistant spores of *Cl. tetani* are killed within 18 hours. To insure the destruction of all forms of pathogenes, instruments should remain immersed in the Solution for at least 18 hours.

Secondly...

and of budget-conserving importance, the Solution is designed to safeguard the factory-new qualities of metal instruments, glass and heat treated rubber. It is non-injurious to keen cutting edges of surgical blades and scissor edges. Prolonged immersion will not result in rust or corrosive damage . . . a valuable aid in reducing replacement expense to a minimum.

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especially designed for small instruments, suture tube storage, suspended immersion of surgical blades, are recommended for convenient and practical use with the Solution.

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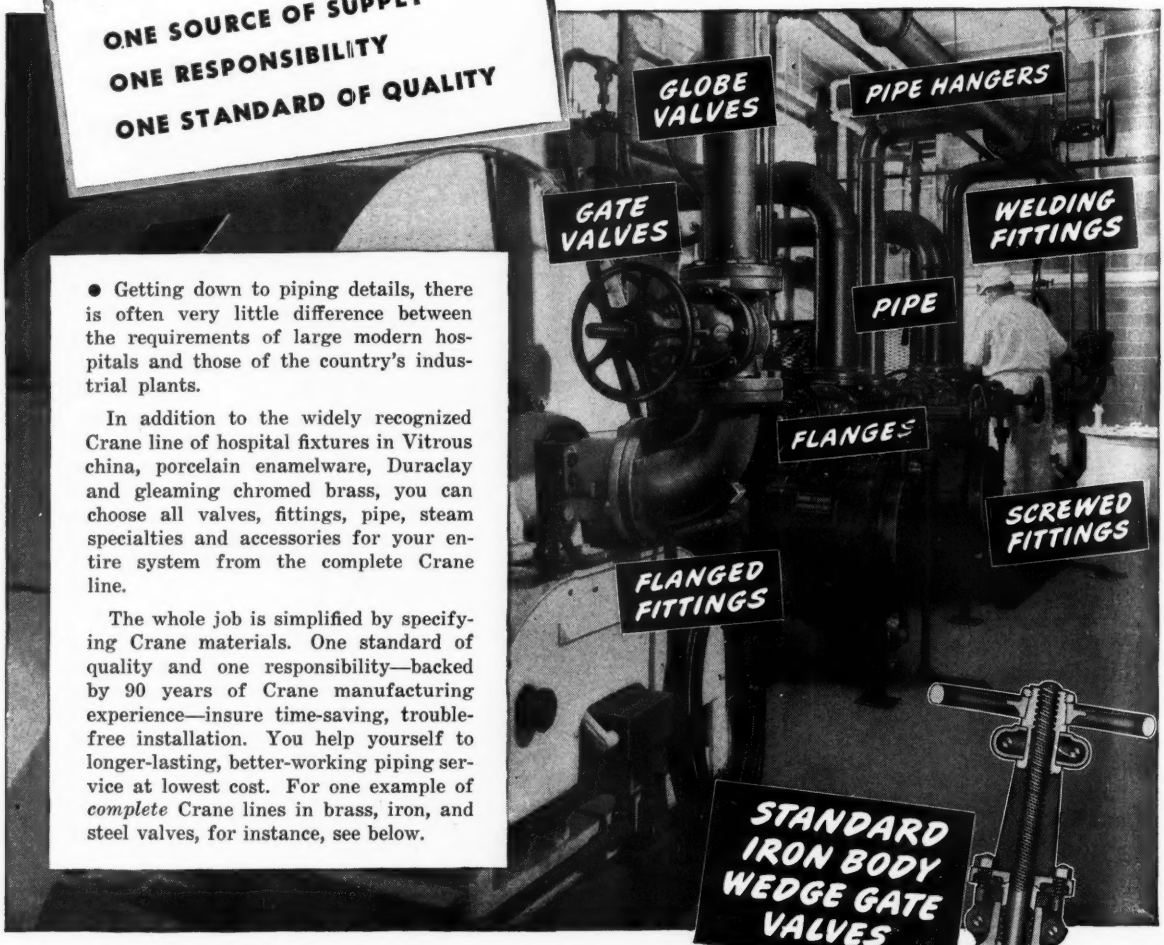


● Getting down to piping details, there is often very little difference between the requirements of large modern hospitals and those of the country's industrial plants.

In addition to the widely recognized Crane line of hospital fixtures in Vitrous china, porcelain enamelware, Duraclay and gleaming chromed brass, you can choose all valves, fittings, pipe, steam specialties and accessories for your entire system from the complete Crane line.

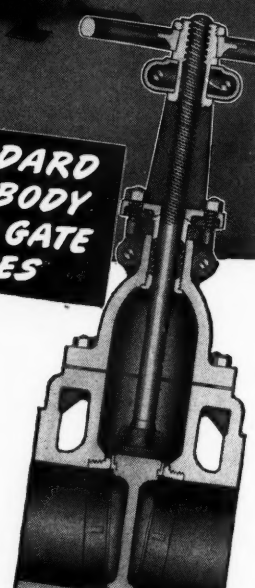
The whole job is simplified by specifying Crane materials. One standard of quality and one responsibility—backed by 90 years of Crane manufacturing experience—insure time-saving, trouble-free installation. You help yourself to longer-lasting, better-working piping service at lowest cost. For one example of *complete* Crane lines in brass, iron, and steel valves, for instance, see below.

SERVICE RECOMMENDATIONS: **Crane Standard Iron Body Wedge Gate Valves** are suited for many services in process and power lines at all working pressures up to 125 pounds steam. Brass-trimmed valves are recommended for steam, water or oil lines; all-iron valves for oil, gas or fluids that corrode brass but not iron. Made in O. S. & Y. and Non-Rising Stem patterns. See page 101 of your Crane Catalogue.

Working Pressures

Size of Valves	Screwed or Flanged Valves		Hub End Valves
	Saturated Steam	Cold Water, Oil, or Gas, Non-Shock	Cold Water or Gas Non-Shock
2 to 12 in.	125 pounds	200 pounds	200 pounds
14 and 16 in.	125 pounds	150 pounds	150 pounds
18 to 24 in.	*	150 pounds	150 pounds
30 in.	*	120 pounds	120 pounds

* For steam lines larger than 16-inch, Crane 150-pound Cast Steel Gate Valves are recommended. (For sizes under 2-in., use Crane Clamp Gate Valves.)



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Harvey Agnew, M.D., Editor

The CANADIAN HOSPITAL

Toronto, May, 1946 Vol. 23 No. 5

Postwar Trends in Public Health and Medical Practice

R. P. VIVIAN, M.D.,
Strathcona Professor of Health and Social Medicine, McGill University, Montreal.

ADVANCES in medical science have finally given curative medicine the ascendancy over disease. Nevertheless, a substantial number of people, because of their place of residence or their economic status, have not as yet benefitted by these advances. It is being recognized, too, that health is not merely the absence of disease but rather a condition of well-being. *Well-being* is a relative term, and there is realization that if a fuller attainment of man's physical and mental capabilities is to be achieved, the average standard of health must be improved.

These observations are being emphasized in public discussion. People everywhere are deeply concerned about sickness and its cost. Responsible governments are attempting to meet this public demand through legislation and the provision of money to implement their proposals. The medical profession generally is fearful of a lowering of professional standards by many of these plans. The tax-payer, while anxious to receive the benefits of an improved type of medical service, is thinking seriously about the stupendous sums mentioned as the cost. He wants to know what actual benefits he is going to receive and how it will affect his taxes.

The trends are plainly visible for those who choose to look. They are developing as an expansion of the public health service with an augmented program, and in the payment for medical care, in whole or in part, from tax-collected funds.

Dangers to be Noted

These trends can be dangerous to the maintenance of the highest standards in the practice of medicine, or they can make possible the most glorious period in medical history.

The danger lies in the adoption of insufficiently considered plans with all their implications. The danger is real as regards both service and cost. As an illustration, I refer to the reportedly unhappy experience in New Zealand with its system of health insurance. Articles now appearing, which I have not seen denied, are stating that the service as it exists is far from complete in character or extent, that the cost is bearing very heavily upon the tax-payers, and that the reputation of the medical profession has been seriously impaired. In using this illustration, I do not wish to belittle in any way the attempt of New Zealand to find an answer to some of the most pressing and perplexing problems in the practice of medicine. I do use it, however, to point out one type of danger.

There is also danger in believing that a type of medical practice successful in some other country or even in another area of the same country may be generally applied with equal success.

In estimating the value of any medical plan we must consider the

Luncheon Address of the Regional Conference of the American College of Surgeons in Montreal, March 22-23.

character and knowledge of the people in the area, the type of service previously in effect, the medical standards of personnel and facilities and the reliability of the statistics. We do know of tax-based programs which are successful as regards both service and cost. The success of these plans, in my opinion, can be directly attributed to the character of the people and their knowledge in matters of health. I am inclined to believe, however, that one of the plans most persistently advertised as successful in a country lacking freedom of speech, freedom of the press and freedom of unbiased investigation is little more than the rosy-hued story of the setting up of something where nothing previously existed.

On this continent there are successful tax-based medical care programs of limited character that suit the region for which they were designed. Addition to these programs would improve the scope and quality of the service. The whole could provide the maximum possible for the areas concerned. In certain localities this system should prove to be excellent. If such a plan were wholly transplanted, it might suffer the fate of so many transplants—death from inanition in foreign soil because the ingredients for success were lacking in the new surroundings.

A tax-supported plan for medical care presents many problems. In my opinion it must be sufficiently flexible to be adaptable to the varying conditions encountered. It must maintain the highest standards in medicine. It must not place an undue burden upon the taxpayer who is able to maintain a good state of health.

There is still another danger and an equally important one: the refusal by those with special knowledge of the problems to assist fully in solving them. The medical profession is included in this group possessing special knowledge. It is the duty of the medical profession not only to achieve advances in medical science but to guide the method by which these benefits may be more adequately distributed. The medical practioner has in the past been so occupied with curative or palliative measures for his individual patients that he has lacked the time and frequently the opportunity to do much for the prevention of illness or injury. It is true that through him many cases of communicable disease in children have been prevented by smallpox vaccination or active immunization against diphtheria. The doctor has had the opportunity to guide only the relatively few individuals who *sought* his assistance in achieving and maintaining a good state of health. The broader field of communicable disease control, the development of the hygiene of the environment, which is sanitation, standards of nutrition and the protection of food, as well as health education, have been left to the Public Health service, where such existed, or else it has been neglected. The trend in public health is to extend this service and to augument the present program.

R. P. Vivian, M.D.

Public Health Development

I would like to remind you that the public health service has developed as a responsibility of governments for the people they are elected to serve. It was born of a fear on the part of the people of the potential hazards of their environment from miasmas, graveyards, night air and stagnant water. It was raised on its value in the control of plague and, subsequently, of other communicable disease. It developed into adolescense with the institution of sanitary procedures for the more adequate disposal of wastes and the purification of supplies of water and milk. The high maternal and infant mortality rates at the beginning of this century led Public Health into the field of maternal and infant hygiene. It subsequently was asked to undertake programs in the safeguarding of food supplies and the hygiene of industrial environment. With the passing of the so-called "latrine era" and the establishment of certain successful dealings with special or smaller groups of people within a community, the possibilities for a new type of service became apparent. This concept was to serve more directly the practitioner in curative medicine by undertaking a supportive service in those matters with which he could not deal.

It is true that in some instances this service seemed to be at odds with the individual practitioner. When this occurred it was primarily the fault of application rather than of principle. Whatever fault there may have been, it did not always lie with the public health service. I wish to make it quite clear that the true role of a public health service is a supportive one. It can undertake to render invaluable assistance to the practitioner in curative medicine as well as to the community.

I have stated that the trend of the time is to extend the public health service. There are some members of the medical profession who are fearful that this service might be asked to undertake a program in curative procedures for individuals. In my opinion, such a program in state medicine would be disastrous since the character of the tasks is so entirely different. Two services are required: one for the group, the other for the individual. For either group to undertake the work of the other would only mean a serious deterioration in the standards of both. They are complementary, not antagonistic.

It is in problems such as these that I feel the medical profession as a whole can do much to guide the development of the trends in this postwar period.

The public is prepared to vote the tax money required to support programs for the improvement of health. The people are demanding that their elected representatives proceed with such legislation as is required. It is our duty, as a profession, to help in the attainment of a sound program at a reasonable cost.

A Suggested Program

How can this be done? I believe that it can only be accomplished by a clear allocation of the component parts of an over-all program to those best able to develop them, and to blend the whole into a flexible measure.

The component parts with which we are concerned lie in the fields of Public Health, Social Welfare and Medical Practice. Their combined developments and the means of financing them are actually Social Medicine.

The public health service must be further developed in its true role. This consists of the achievement of the optimum in hygiene and preventive medicine for groups of people through the health unit system, undertaken by full-time specialists in this field, employed on a salary basis and paid out of tax-collected funds. In this way an extensive program in health education can be carried out at minimum cost. The augumented program can be of great assistance to medical practice in the earlier discovery of individual defects of health and the reference of the patients to the practitioners of curative medicine. To this end the establishment of well-distributed diagnostic clinics could be of the greatest help. Far too much of the individual physician's time and the patient's money are spent in seeking the cause of the trouble.

Social Welfare Aspect

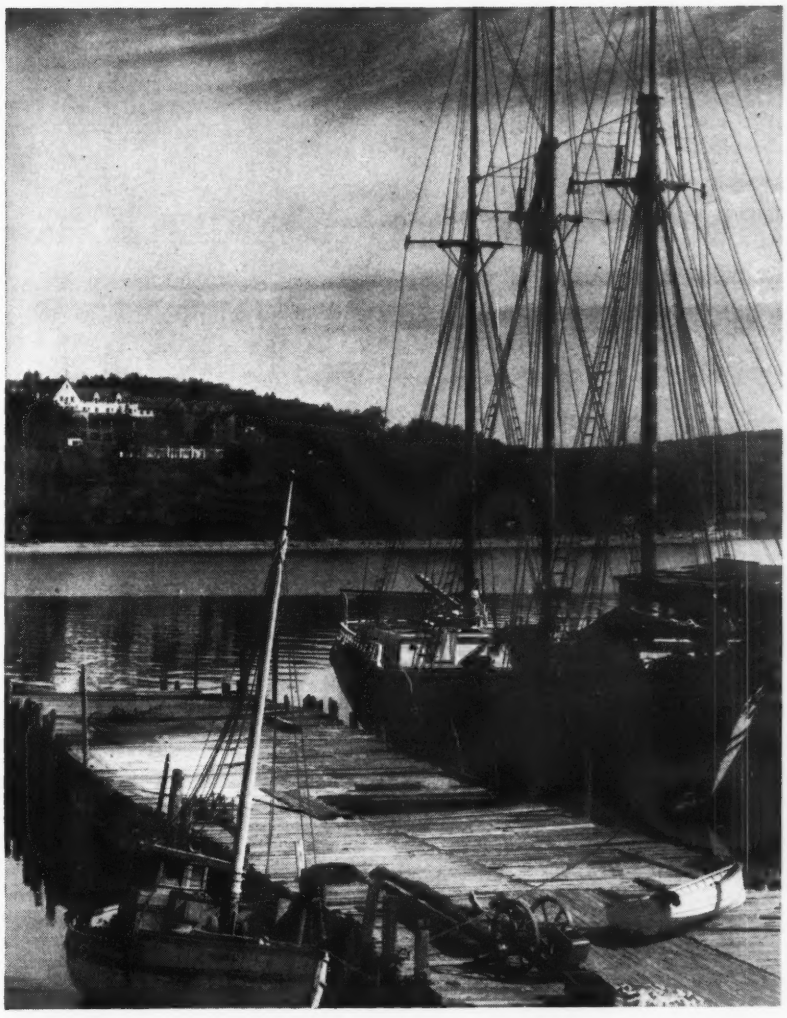
Closely allied with the public health system should be the development of a *social welfare* program on a unit basis for both metropolitan and rural areas. It could combine the efforts of both public and voluntary agencies. Such a development could make adequate provision for the destitute, the neglected and the chronically ill, by the sound application of reasonable amounts of tax-collected funds. It could also undertake to give invaluable assistance to families in the solution of social and economic problems.

Medical practice can be benefitted by the provision of adequate personnel and facilities and by the lowering of the cost of medical care to the individual patient.

Both these difficulties can be solved by the provision of money. The way in which money is provided and the way it is used must be most carefully considered. The individual should bear directly some portion of the cost of health services. The principle of social insurance is dangerous in that it would seem to offer unlimited service on a supposedly prepaid basis without adequate control. An unsatisfactory system of health insurance would probably lead directly to medical practice condueted on a salary basis. The two essential factors for the maintenance of sound procedures in medical practice are the retention of the patient-doctor relationship and the incentive of the patient to maintain health.

It is necessary that tax-collected funds be used for an extension of the facilities and an improvement in the conduct of medical practice. Partial subsidy could meet the requirements. It could be used to pay a portion of the cost of medical care, leaving the balance to be paid by the individual or by the welfare agency responsible for his care when the service was required.

Such a system would permit accurate estimation of the amount of tax money required. It could provide for the establishment of definite rates. It could permit a screening-out of minor expenses which should remain an individual obligation. It would maintain the patient-doctor relationship and the individual incentive to attain and maintain health through the programs in public health and social welfare.



Where the Maritime Hospital Association Will Meet.
The Pines, Digby, N.S., June 25-27.
(C.P.R. Photograph)

Should Nurses' Associations Act as "Bargaining Agents"?

TODAY there seems to be too much uncertainty concerning what hospitals should pay nurses, or personnel in general and, conversely, what applicants should ask. No sooner do salaries and wages seem to be reasonably well stabilized in an area than some person, or group, or institution, gets out of line and the whole question is opened again.

The suggestion has been made several times, "Could not the hospitals as a whole, in an area or in a province, set schedules for different positions?" And it has been proposed also that, instead of having individual nurses try to make the best deal possible for themselves, their provincial or local association might work out salary levels with the hospitals on their behalf. It has been stated that much pressure has been brought upon nurses, and sometimes by nurses, to affiliate with organized labour groups and make them their bargaining agents.

To obtain a cross-section of viewpoint, opinions were sought from various prominent people in the hospital and nursing fields, either as representative of a particular organization or as a personal opinion.

Questions

(1) *In determining minimum salary levels for general duty and other types of nursing service, should these be left to the discretion of the individual hospital, or be determined on a regional basis by a local hospital council or by a hospital association acting as the bargaining agent for its members?*

(2) *If the latter course be acceptable, should the provincial (or other) nurses' association be recognized by the hospitals as a bargaining agent on behalf of the nurses?*

Uniform Minimum Salaries

Sister M. Ignatius, Reg.N., Antigonish, N.S.

It does not seem in keeping with present trends that the individual hospital should determine the nurses' salaries for the different types of service. At the present time there is much unrest and dissatisfaction among nurses due to the difference in salaries paid by hospitals in the same town or district; this applies also to the hours of work.

Miss F. Munroe, Reg.N., Montreal, Que.,
President, Canadian Nurses' Association.

It would seem better that levels of salary for hospital nursing staffs should be determined on a regional basis through a conference between the authorized representatives of the hospitals or hospital associations and authorized representatives of the nurses concerned.

Miss A. J. MacMaster, Reg.N., Moncton, N.B.

I believe that there should be a minimum level of salaries applicable to a particular area, and that the scale should be based on a proper classification of hospitals.

Miss Jean Masten, Reg.N., Toronto, Ont.

It is extremely satisfactory to have a local hospital council (or regional conference) determine the minimum salary levels. Since this procedure has been followed in Toronto, the "shopping around" that formerly went on has been eliminated. It gives a fair chance to all hospitals to compete on the same level and, indirectly, does a good deal to improve the amenities and personal practices in order to hold the staff members.

Miss M. Blanche Anderson, Reg.N., Ottawa.

It seems reasonable that provincial hospital associations should determine minimum basic salaries for hospital nursing personnel. If determined on a regional basis, lower living costs in smaller centres should not be unduly emphasized, being more than offset by lack of opportunities and advantages.

Sister Medeleine of Jesus, Reg.N., Ottawa.

It would seem advisable to have minimum salary levels for general duty and other types of nursing service determined on a regional basis by a local hospital council because of the desirability of uniformity of payment and to offset the trend towards joining outside unions.

W. C. Ryan, Regina, Sask.,
President, Saskatchewan Hospital Association.

The minimum salary in any hospital ought to be the minimum for all hospitals large and small. There should be a joint agreement between the provincial nurses' association and the provincial hospital association as to minimum salaries and conditions of maintenance.

Miss Elizabeth B. Rogers, Reg.N., Edmonton, Alta.,
Registrar, Alberta Association of Registered Nurses.

In Alberta, from a legal standpoint, the Alberta Industrial Conciliation and Arbitration Act outlines the procedure that must be followed. According to my interpretation of this Act, all actual bargaining from an official *legal* point of view must be between the individual hospital authorities and their employees.

Judge J. Milton George, Morden, Man.

Uniformity of salaries for nursing service in hospitals is most desirable. This can best be accomplished by a uniform salary for each of two groups in hospitals—city and rural—being arrived at through a conference between the provincial hospital association and the provincial nurses' association. The suggested standard of salaries should then be furnished to each individual hospital urging that it be used as a basis of negotiation between each hospital board and its staff.

The suggestions should also cover other details, such as holiday periods, sick leave, maintenance, uniforms, laundry, etc.

A. K. Haywood, M.D., Vancouver, B.C.

There is a Joint Committee on the stabilization of nursing service representing the British Columbia Hospitals' Association and the Registered Nurses' Association of British Columbia. A schedule of salaries was prepared by this Joint Committee in 1944 and approved by both associations.

(Note: The Montreal Hospital Council has been certified as a bargaining agent on behalf of hospitals.—Editor).

Recognition of Nurses' Associations as "Bargaining Agents"

The Labour Relations' Committee of the Canadian Nurses' Association has given much thought to the whole question of employment conditions for nurses. Some nurses now belong to employee associations and civil servants' associations affiliated with trade unions. While the Committee in its 1944 report was "not prepared at the present time to make any definite recommendations", it did state that "For groups who are faced with immediate decisions the Committee feels that no nurse should become a member of an association or trade union under conditions that might call for the stoppage of necessary nursing service, i.e., to strike." The Committee pointed out that it is possible to join a trade union with special reservations, necessitated by the type of service given by a profession or group.

In its 1945 report the Committee, in discussing whether or not professional registered nurses should become members of trade unions, stated "The thinking of your Labour Relations' Committee is that, solely for the purpose of collective bargaining, they should not". At the same time the Committee urged a "tolerant" attitude toward this type of organization.

Miss F. Munroe, Reg.N.

The Canadian Nurses' Association has gone on record as approving of the principle of collective bargaining for nurses and has recommended that each provincial nurses' association explore ways and means of keeping the bargaining power within the professional group. It was definitely felt that members of the provincial nurses' associations should be able to look to their provincial and national associations for assistance in collective bargaining agreements.

In Quebec, the Registered Nurses' Association of the province has been certified as the bargaining agent for nurses.

Miss M. Blanche Anderson, Reg.N.

The term "bargaining agent", so generally used in industry, does not indicate the relationship nursing organizations should hold to hospital organizations. Rather co-operation is needed and the interests of neither side should be subordinated to the other.

Canadian and provincial nurses' associations should be *advisory* in all matters of general concern to nursing and nurses.

W. C. Ryan, Regina.

There is a school of thought that believes it is dangerous to recognize any bargaining agent; however, it is equally true that the trend of the times is toward unions. Therefore it would be in the best interests of all concerned if the provincial registered nurses' association could be recognized as a bargaining agent for the nurses.

As the bargaining agent the association could negotiate with the individual hospitals regarding salaries, hours of work, statutory holidays, vacations, etc.

Sister M. Ignatius, Reg.N.

It would seem more satisfactory to have the provincial registered nurses' association and the provincial hospital association act as bargaining agents in determining the amounts to be paid for the various types of nursing service, working hours, etc.

(The Maritime Hospital Association has appointed a representative of each provincial registered nurses' association, three in all, on its Executive Board. They will be given time at meetings to discuss any problems that may arise. I think that this is going to create a much better understanding and a much better spirit between the two groups).

Miss A. J. MacMaster, Reg.N.

If a bargaining agent is unavoidable, the logical agent for graduate nurses in the hospital field would be their official organization.

A. K. Haywood, M.D.

If the Registered Nurses' Association of British Columbia is prepared to set up a certifiable bargaining group on behalf of nurses employed in the hospital, the hospital, as an employer, is required to recognize such a bargaining group. This is implicit in a labour law now in force. (P.C. 1003).

Miss Jean Masten, Reg.N.

Used in a general sense to indicate a group that would be prepared to sit on a joint committee and represent hospital nurses, the term "bargaining agent" seems suitable, but the Registered Nurses' Association of Ontario has been advised by its legal counsel that it is not desirable that this association have itself appointed the official bargaining agent.

For purposes of convenience and representation in a professional group, I think the provincial nurses' association is a good choice. The points against this idea seem invalid. If the nursing group cannot trust their own organization to support their best interests, they are unlikely to accomplish anything in a disorganized fashion.

Miss Elizabeth B. Rogers, Reg.N.

The Alberta Industrial Conciliation and Arbitration Act permits representatives from an Association such as ours to act as members of the bargaining committee *if requested so to act by the employees appointing a bargaining committee.*

Sister Madeleine of Jesus, Reg.N., Ottawa.

The bargaining agent for the nurses could well be the district or regional group of the nurses' association. It might be advisable to have a representative from the local Central Registry on this committee.

Should Bargaining Agent Include Other Than Hospital Nurses?

In commenting on the possible objection that a provincial nurses association includes many more than hospital nurses, Miss MacMaster wrote: "It appears to be a great strength that nurses other than hospital employees would have a voice in determining policy. Hours and salaries in the public health agencies have been a main source of discontent and have had much more to do with the draining off of nurses to that field than any very convinced preference for the work. Some balance should be arrived at. Similarly the private duty nurse should be in touch with other branches of nursing, maintaining a comparable rate and not withdrawing into an autonomous group making its own rules and standards."

In this connection Miss Munroe stated: "Nurses who are not hospital employees and have a disinterested approach might have much of value to contribute to any conference regarding bargaining."

Summary

From these representative comments, personal or official, one would conclude:

(a) The present practice of having nurses "shop around" and of having hospitals conform to no uniform minimum salary, but pay varying amounts is not satisfactory.

(b) Salaries should be uniform for a given area. The provincial hospital association or the local hospital council or regional conference either should fix minimum salaries or should recommend standards to the hospital concerned.

(c) Consultation with the nurses' association is either recommended or has proved valuable in actual practice.

(d) Recognition of the organized nursing profession as a "bargaining agent" is supported and, it is noted, is recognized by legislation in several provinces.

(e) The replies were not as definite that the hospital association should be the "bargaining agent" but the nature of the first question would imply that this be so.

(There was some ambiguity respecting Alberta. The Act was interpreted as requiring all bargaining to be between the individual hospital authorities and the employees, yet, later on, the nurses' association is said to have that power if requested so to act by the employees.)

(f) The fact that provincial nurses' associations include other than nurses employed by hospitals is regarded as an advantage rather than an objection.

(g) The term "bargaining agent" is repugnant to some, as it suggests tactics adopted by some union spokesmen. Some such term as "representative", "negotiator", "adjuster" or "conciliator" might be more acceptable.

What are YOUR views on these questions of (a) uniform minimum salaries and (b) bargaining agents?

Time to Speak Clearly

It is high time for the medical profession to speak more clearly to the American public on the variety of proposals and plans affecting doctor-patient relationships which citizens now regard as a heritage of freedom. A well-organized propaganda actually has convinced many citizens that the medical profession stands in the way of better health services and facilities in our nation. Physicians generally have been in the front ranks of those best serving the community. Their very considerable personal sacrifices in serving the economically-depressed citizens are not forgotten by thoughtful leaders in social welfare. The profession's recommendations for constantly better standards of medical education, of hospital administration, and of more extensive public health programs are chiefly responsible for the magnificent progress in national health noted throughout our country. Government controlled and administered medical services have nowhere equalled the record achieved by this nation's traditional system of private medicine. Medical men should not permit a species of totalitarian propaganda to push them into a position of alleged opposition to better and to more widely attainable medical services for the people. The physicians and surgeons want what all decent citizens want. They want the public to have the best service and the best hospitals at the fairest cost to all.

Our citizens should exercise eternal vigilance in appraising plans and programs which hinder the individual from his right to select his own physician and which order a physician to engage his talents and skills according to bureaucratic control. It is well to remember in these days of sacrifice and death and struggle for liberty that so-called government benevolence can hide in edicts and decrees an even greater multitude of sins than charity can possibly recover.

The watchword of a possible American totalitarianism will not be "Heil der Fuehrer" nor "Proletariat Unite" but some version of "The State, like mama, knows best—take it and like it!"

The Most Reverend Michael J. Ready, D.D., Bishop of Columbus, in "The Linacre Quarterly".

Present Day Trends in Obstetrical Care

NEWELL W. PHILPOTT, M.D.,
Acting Chairman, Department of Obstetrics and Gynaecology, Royal Victoria Montreal Maternity Hospital.

COINCIDENTAL with the progression of time, care of the expectant mother has changed considerably. In Biblical days a woman who was about to give birth was considered "unclean." Approximately forty days before her appointed time had arrived she was put by herself; thus she stayed throughout her labour and for forty days following delivery. Even to-day this custom is still followed in certain uncivilized parts of British India.

But, as civilization progressed, so did the care of the maternity patient. The female midwife was allowed to assist the patient in her hours of trial. During the Grecian period we find definite interest of the male doctor in the field of midwifery. It was at this stage that the medical man first made a concerted effort to usurp the rights of the female midwife. The fight was furious and the midwife won for a time. A law was passed to the effect that no male person could attend a woman during labour. Most medical men lost heart and the interested medical personnel moved to Rome, where much progress was being made. Midwifery in an organized manner soon spread to France, to Germany and to England.

During the nineteenth century the techniques of "asepsis" and "antisepsis" were developed. It was realized that the old idea of isolating the maternity case was really sound, not because she was unclean, but for her own protection. Maternity cases were found to have fewer complications when they were removed from among the general medical or surgical patients. This was the prime factor in the creation of the "Frauenklinik."

In more recent years Colebrooke at the Chelsea Hospital in London has gone further. He has proven that contacts frequently cause mild or severe sepsis in the maternity patient. For this reason all attending personnel on a maternity ward are obliged to have their own nose and throat cultures examined, thus helping to eliminate the "streptococci carrier". Patients who show evidence of any septic condition are immediately isolated.

To-day in America we have progressed more or less along these lines. As a result the larger cities have developed maternity centres to be used exclusively for maternity cases. General hospitals in the various cities have their maternity wings with case-room facilities reserved exclusively for obstetrical work. The community hospitals have maternity wards and case-rooms separated from the general medical or surgical patients.

For many centuries parturition had been considered a normal process. The policy had consequently been "let nature follow her course". But times have changed and we now realize that the parturient woman may be a real hazard. She should be treated with the same meticulous care as one would treat any surgical case, for she is susceptible to infection, haemorrhage or toxic manifestations. Any of these complications may prove fatal. In addition one can never neglect the fact that we are dealing with two lives. It is essential to have the mother and her baby live; they should also be *well.*

Home vs. Hospital

There has been in years gone by much controversy about the relative safety of home or hospital delivery. Interested individuals can find arguments on either side. The chief argument in favour of home delivery has been relative to infection. A woman in her own home becomes immune to her own germs and she does not come in contact with many outside contaminations. This is not true in hospital. However, the situation has entirely changed with the advent of the sulphonamides, penicillin and streptomycin.

Arguments in favour of hospital delivery, especially for the primipara, far outweigh any disadvantages. Trained personnel and modern facilities swing the balance. Operative procedures, treatment of haemorrhage and even the treatment of sepsis is more efficiently executed in an institution.

To-day there is an added feature, the social side of family circumstance. People would rather have their babies in hospital; it is more convenient for every social level in the community. The poor person has no adequate help at home. Another patient might be fortunate enough to have a maid, but maids do not relish childbearing in their place of abode. At the present time, in city or town practice, patients insist upon hospital delivery.

During recent years, conditions have changed in the Royal Victoria Montreal Maternity Hospital. Before the war we delivered over 500 cases each year in the home. This was a fine service rendered the community and, in addition, it provided excellent teaching material. During 1945 we delivered only 59 patients in their homes. In 1938 L'Assistance Maternelle delivered over 5,000 home cases; this has dropped to less than 25 per cent of that figure. The Boston Lying-In Hospital had a large outside service in pre-war days; last year they disbanded this service because patients demanded hospital delivery.

Our results in the Royal Victoria

An address presented at the Regional Hospital Conference of the American College of Surgeons in Montreal, March 22-23. Dr. Philpott is Associate Professor of Obstetrics and Gynaecology at McGill University.

Montreal Maternity indicate the value of good hospital care. Last year 2,782 cases were delivered with only two maternal deaths. The foetal mortality was 3.8 per cent. This includes all deaths of mothers and babies from the time of admission until discharge from hospital.

Maternal and foetal mortality generally throughout Canada is over twice as high as I have shown in figures for this hospital. It is true that we have ideal circumstances under which to work. In addition we have trained personnel to handle every type of case. To counteract these assets, however, we were obliged last year to handle 152 emergency cases. Several of these individuals had never seen a doctor during pregnancy; others were referred by outside doctors or from smaller hospitals on account of complicated pregnancy or labour; and still others were referred on account of sepsis or haemorrhage following delivery.

Responsible Factors

Credit for good results should first go to well-trained *medical personnel.* Also one must take into account the advantages of *adequate hospital facilities.* These include: disproportion clinic, haematology laboratory, blood bank, bacteriology laboratory, toxaemia clinic, special nurseries for premature and sick babies and isolation facilities for infected mothers and babies.

Disproportion cases should have expert care. Proper examination plus the use of x-ray pelvimetry has saved many a mother. In addition, craniotomy and many difficult forceps cases have been eliminated. As a result the foetal mortality and foetal damage has been decreased considerably.

Anaemia of pregnancy is common. It is frequently the predisposing factor of haemorrhage at birth or sepsis following delivery. Incompatible blood frequently complicates transfusion of the pregnant or recently-delivered woman. Babies are offtimes affected by this incompatibility. This is referable to rhesus factor determination. For these reasons *blood studies* should be supervised by experts.

The *blood bank* plays an important role in maternity practice. Facilities for transfusion should be made available for every maternity case, whether in the hospital or in the home. It is a life-saver. This provision should be undertaken by some central organization which could administer an efficient unit for the whole community. During the last year we gave 512 blood or plasma transfusions, averaging almost two per diem.

Every maternity hospital should have facilities for doing *bacteriological* examinations. Definite diagnosis of the organism which causes trouble in the mother or baby plays an important part in determining the treatment which should be followed. *Serological* studies are essential. In the last 20,000 consecutive cases in our pavilion, we diagnosed 509 active luetics, an incidence of 2.5 per cent. Most of these cases were adequately treated during pregnancy. The results were excellent.

Treatment of the toxic patient has changed considerably. It is essential for the patient to be admitted to hospital. Incidence of eclampsia in supervised hospital practice is almost negligible. Each year we still admit to hospital many toxic cases which are late in being diagnosed or which have been inadequately treated.

Any large maternity centre should have a *premature nursery.* Expert staff and proper equipment is essential. Air-conditioning and air-sterilization play an important role in the successful progress of the babies. Facilities for oxygen therapy to every baby are very necessary. Storage of breast milk should be part of the unit. Of course incubators and heated cots should be used exclusively unless super-heated rooms are preferred. Our personal experience is that each baby should be treated as an individual in its own incubator with a temperature and even humidity-control suitable to that one particular baby.

Isolation wards for mothers and babies are a "must" in modern maternity hospitals. If doubtful or septic cases are removed from clean wards there is little to fear from widespread sepsis. In a well-run isolation ward with proper technique, mothers and babies are safer from cross-infection than in many other wards.

Pertinent Questions

Larger maternity centres should lead the way in providing general equipment and in medical and nursing technique. They should lead in *investigative work.* The questions are frequently asked, Should the baby be placed with the mother? What is the place of physiotherapy in obstetrics? Should an educational programme be carried out for the patient? Is this medical education of the patient a public health problem or a responsibility of the obstetrical division?

Should the baby be placed with the mother? We are all aware that most home deliveries are completed by placing the baby in a cot beside the mother. There it is left constantly during the first few days of life. The mother is vitally aware that she possesses a baby. Perhaps she misses this maternal stimulation in a large hospital.

Interesting experiments in this connection are being carried out at Yale University and elsewhere. The results of this medical and psychological study should be most interesting. Most English hospitals do place the baby with the mother. Under such a system it would be essential to have separate rooms for every patient-baby combination. Apparently a mother does not mind tending her baby and listening to its cries. But she does not wish to be bothered, especially shortly after delivery, by the cries of several other babies, which would be the case in semi-private or general wards. Contamination by visitors would also need consideration.

What is the place of physiotherapy in obstetrics? Much can be accomplished in this regard. During pregnancy more emphasis should be placed upon posture and muscle exercise. Massage is most beneficial in certain cases. After delivery a definite programme of exercise should be studied. There is controversy with regard to early rising, but most physicians will agree that supervised passive exercise is very beneficial. The use of short-wave therapy to facilitate involution should also be more widely used. Dry heat applied to the breast and perineum is most beneficial.

Should an education programme be carried out for the patient? This should be developed. We teach our patients certain things. Personal hygiene is most important. The mother must know how to care for her baby and she must be taught;

sometimes the best private patient knows the least about the baby. Patients are also taught the values of certain foods—the importance of calories, vitamins, calcium and iron —and how foods should be cooked. Health conditions in the home should be investigated; this last is under the direction of the Social Service Department.

Is this medical education of the patient a public-health problem, or is it a responsibility of the obstetrical division? This should be a combined effort. We would welcome the development of health centres where pre-natal, post-natal and educational programmes would be expertly handled under the direction of public health personnel.

May I state in conclusion that the larger obstetrical centres should not expect to deliver *every* patient in the area. Many patients, and especially those in the surrounding districts, will still be delivered at home. Also those patients who prefer the local hospital should be afforded adequate accommodation. Complicated cases should always have the privilege of the best type of hospital care.

"If it is important to be in this world at all, and indeed we think it is, surely the matter and the manner of our arrival is of first concern."

Shut-In's Day to be First Sunday in June

The Shut-in's Day Association has asked that Sunday, June 3rd, be observed as Shut-in's Day on which day it is desired that our people remember those who are sick or disabled and who are confined to their homes, hospitals or other institutions through illness or disability. It is suggested that this be done by visits or letters. Quite a number of Canadian cities issued proclamations last year announcing the date of Shut-In's Day and it is expected that a still larger number of cities will do so this year. This movement has been endorsed by leaders in public and church life and by a wide range of organizations, including the Canadian Hospital Council. Widespread observance of this day should do much to bring cheer and comfort into the lives of many who find their days long and dull.

New Workmen's Compensation Agreement in Ontario

After much negotiation and a careful analysis of the operating costs of hospitals in the province, the Ontario Hospital Association and the Workmen's Compensation Board have agreed upon a new basis of payment to hospitals.

The payment made for hospital maintenance will be 95% of the "going rate" in the various hospitals as of April 16, 1946, plus certain extras, with the understanding that the maximum payment shall not exceed $5.00 per diem plus extras as now paid. This arrangement will be retroactive to January 1st, 1946 and will remain in force until the end of 1947.

It is understood that some consideration will be given by the Board to payment for certain extras which are not now being paid for by the Board and that a study will be carried out to ascertain the exact costs of these extra services, payments eventually to be on that basis. It is understood also that in the case of certain hospitals which, for various reasons, have a different rate schedule from that normally set up by hospitals, special consideration will be given.

Mr. A. J. Swanson was Chairman of the special committee which worked out these arrangements with the Board.

C.P.R. Photo

Sweet May hath come to love us,
Flowers, trees their blossoms don;
And through the blue heaven above us
The very clouds move on.

—Heine.

A Basis of Visual Education

Medical Illustration

By MARIA WISHART, Director,
Department of Art as Applied to Medicine,
University of Toronto.

MEDICAL illustration, including under that term line and wash drawings, black-and-white and coloured photography and natural colour wax moulds known as *moulages,* has become so accepted as a medium in teaching that it is now the basis of a still wider conception, that of a Visual Education Department, or Centre, as it is called in some places.

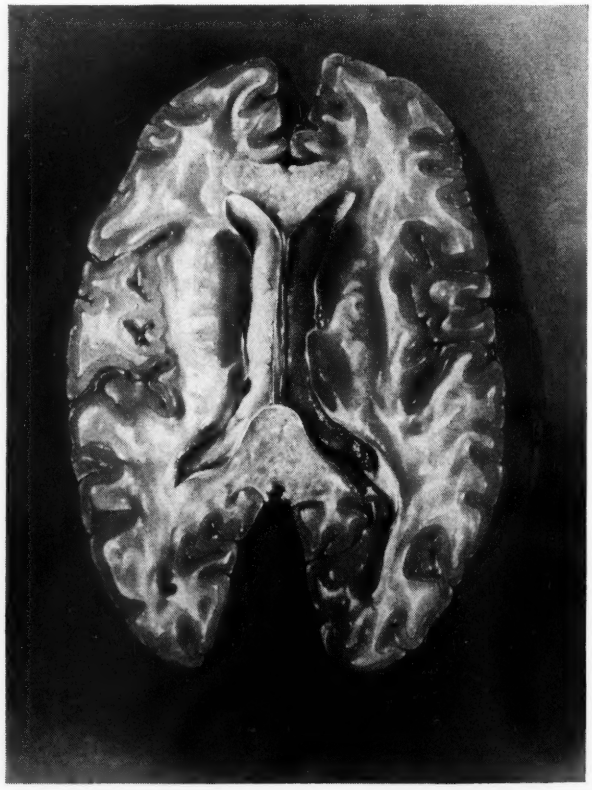
Such a centre is rapidly becoming a necessary unit of a well-organized hospital. Its *function* is to record and interpret the scientific work of the medical staff. This is carried out by means of diagrams, drawings, coloured painting, models, moulages, photographs, moving pictures and animated drawings. Its *value* lies in the teaching material which these records furnish, in the wide-spread publicity that can be obtained by publication and exhibition of them, and in the general interest it promotes among the medical staff, by familiarizing them with the work of one another.

Few people have the ability to form a clear-cut mental picture from the spoken or written word, yet the ability to do so makes the absorption and retention of knowledge easier. To-day doctors are recognizing the value of visual education in their teaching of the students. The layman also can be reached more easily by this means, for the barriers of nomenclature, language and varying degrees of education are largely overcome. These pictures, models and photographs executed to simplify and interpret the scientific point, are the doctor's medium for conveying their ideas to their fellow practitioners, to their patrons and to the public at large. Such centres, well set up with display cases for the models and drawings placed in a good light where they can be seen readily, stimulate the interest of the entire personnel of the hospital in the work being carried on by the medical staff.

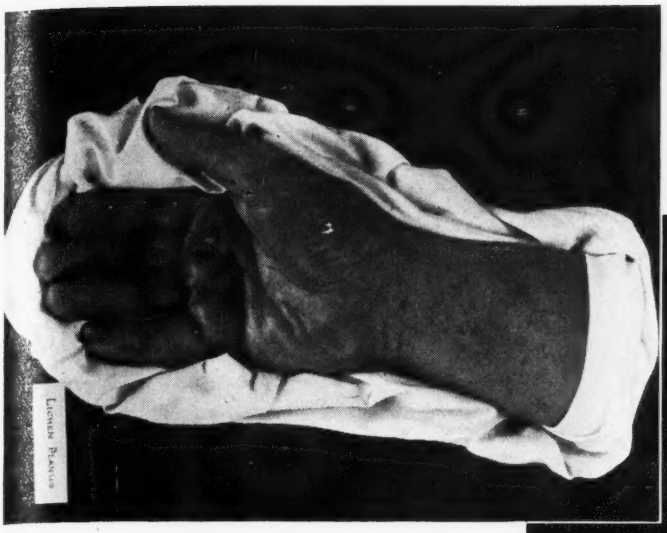
The Medical Artist

In order that the scientific work of the medical staff may be interpreted and presented intelligently, a fundamental knowledge of anatomy and other medical subjects is necessary, in addition to creative ability and technical skills. For this reason a trained medical artist is the logical person to undertake the direction.

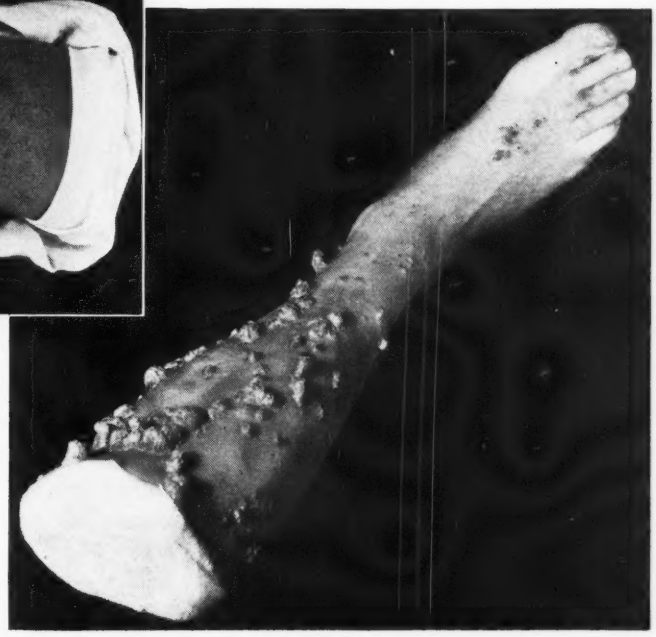
Just what is a medical artist? A lay person is bewildered by the term and the average medical man has little or no conception of the arduous training required to qualify for the profession. A would-be medical artist, in addition to a good basic education, has probably covered a four-year arts course and some pre-medical subjects. In any case he should have developed graphic drawing ability and keen, intelligent interest in science and nature. This



Oedema of the brain. The point was to illustrate the putty-like, highly-glazed homogenous appearance of the brain tissue. The glazed appearance, lost in a myriad of lights reflected from the wet surface of the brain, failed to show clearly in a photograph.



Moulage, meaning to cast or mould, is the term commonly used for these wax models. An object portrayed by means of a "round plastic" as below has a higher teaching value than the older flat "plaque" type, as shown on left, which lacks realism.

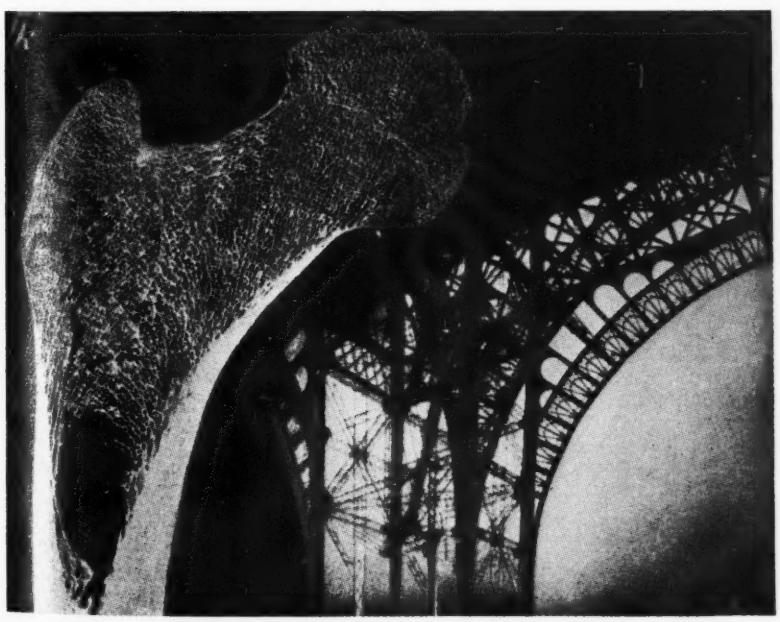


is a difficult combination to find, yet essential to success. No matter how brilliant an artist may be, he cannot interpret that which he cannot grasp, and no matter how intelligent a student of science he may be, he cannot express his knowledge if he is not master of his pencil or has not the ability to visualize.

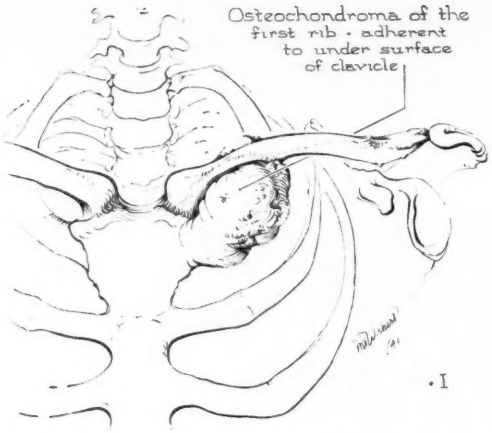
With this background he is then ready to start on an intensive three years' training, including the full course in anatomy, histology and embryology as given to the medical students. Extra dissection and drawing from the cadaver, some pathology, attendance at autopsies, sketching of operative procedures in all fields, training in the use of the otoscope, ophthalmoscope, etc., and studies made with the same; drawings from fresh and hardened specimens; study of the techniques suitable for reproduction; various approaches to the making of wax, plaster and plastic models — all should be part of his training. Finally, a basic knowledge of photography is necessary.

Artist vs. Camera

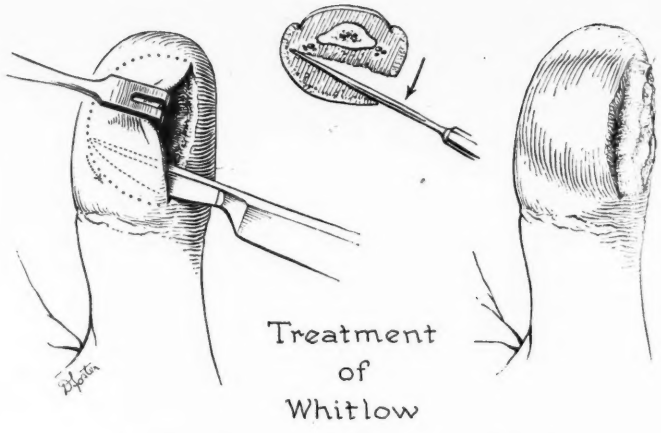
A considerable amount of confusion exists in the minds of many people as to just what a medical artist can do that the camera cannot do as well or even better. Each has its own very distinct field of usefulness, and these should be clearly understood. As the late Max Broedel, Professor of Art as Applied to Medicine, Johns Hopkins Medical School said, "Photography is now used in every branch of medicine; it is employed with great skill, often to the entire satisfaction of the investigator. It shows form, structure, colour and texture, all with complete realism. But it does not analyse, interpret or teach. It gives no answer to the host of inquiries which plague



Photography is used in dramatic fashion to demonstrate that the internal structure of bone transmitting oblique force is similar to that of a supporting tower in a bridge.—By Fritz Kahn in "Man in Structure and Function."



A drawing such as the above permits stripping of non-essential tissues to reveal the pathological condition.

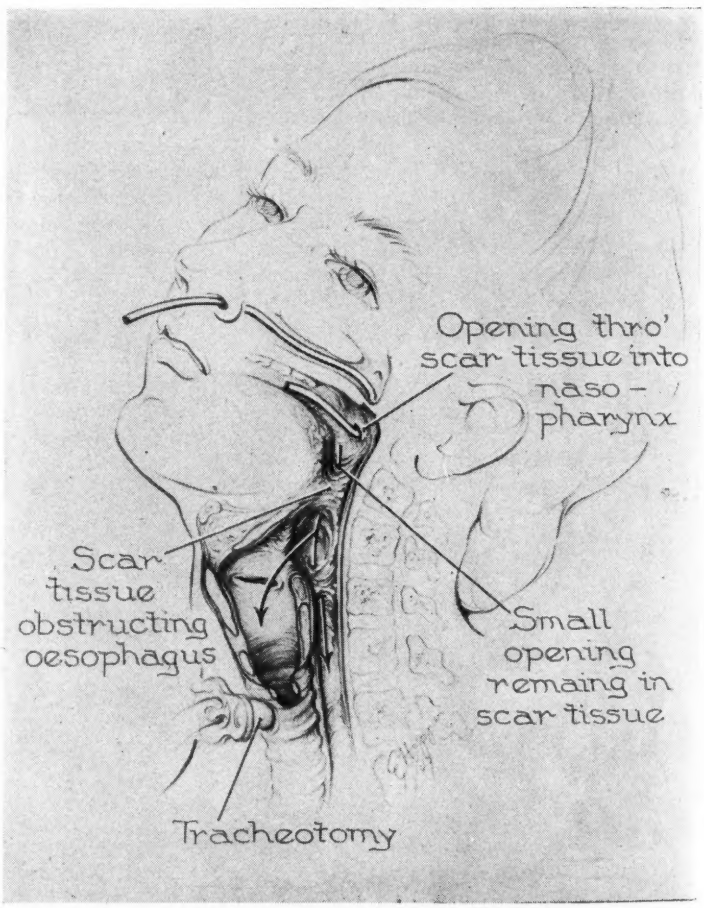


This is a clear-cut example of a complete story recorded in one picture, all extraneous detail omitted, attention focussed on a given point.

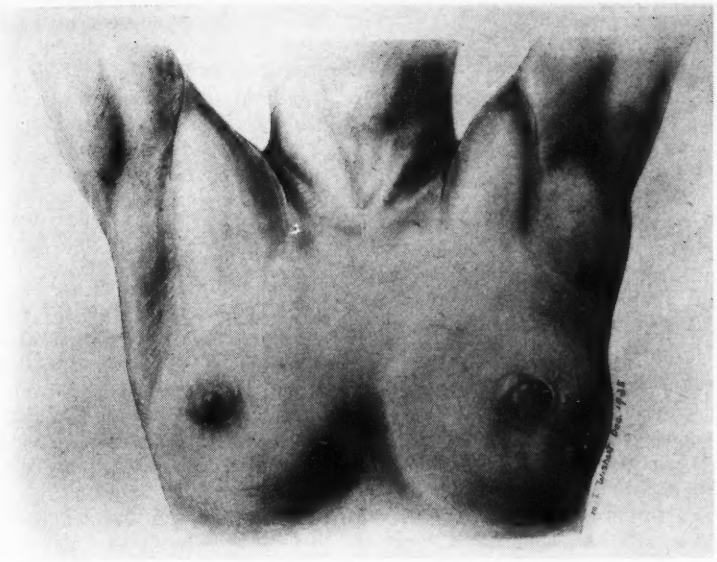
the student. It makes a dramatic picture, not a scientific one."

A simple illustration of their different functions is, for example, a surgical exposure of the brain. A picture of the immediate field as produced by the camera means little to the student—the position of the head, the various landmarks which provide orientation—these are hidden under sheets, gauze, pads, etc. The artist, familiar with the field through training and observation, draws a composite picture, indicating the high lights of the operative technique, yet also incorporating anatomical features. The medical artist is able to reconstruct an accurate mental picture and to produce it "out of thin air" convincingly on paper. Seldom does a doctor wish a subject drawn as it is when he presents it for illustration—the colour has changed, it has been badly cut or incorrectly mounted. The tissues are to be shown as they were when fresh. He wants his own operative view to be shown, although the artist, for lack of room or visibility, may be seeing the field from a reverse or greatly foreshortened angle.

Misuse of the camera and of medical illustration is frequently made by the medical profession; they ask for a subject to be *drawn* which would be better photographed and vice versa. The decision as to whether the subject should be photographed, drawn or a combination of the two, should be the medical artist's, whose trained familiarity with the medical field and understanding of the elements of a pictured story qualify him to judge. Naturally one comes up against diversified opinions. There are the two extremes: (1) the scientist who prefers drawings because he considers the camera a "congenital liar," and (2) the scientist who, lest "artistic liberties" be taken, wishes



Tracheotomy. No photograph could illustrate the story so dynamically or so completely in one picture.



This half-tone drawing of a malignancy of the left breast with axillary involvement is included as an example of a case which would have shown as well in a photograph.

all his drawings based on photographs for accuracy. Both are right to a degree. The camera, in focussing on one plane, frequently distorts, especially in subjects of depth. The good medical artist will not intentionally take liberties, but in very precise drawings based on measurements he probably requires supervision. Usually, however, the shoe is on the other foot, and the artist is frequently asked to indicate something that is not there in order to emphasize the scientist's point. This is why Max Broedel, in listing the qualifications of a medical art student placed second out of seven points: "The ability to study intelligently, to observe accurately and to doubt the statements of authority."

A candidate for membership in the recently-formed Association of Medical Illustrators is required to have a thorough training, a high standard of work, and at least three years' postgraduate experience. This background ensures that a good medical illustrator is competent to take charge of the work and to direct authoritatively the activities of the more technical branches of a Visual Education Department or Centre.

Conclusion

This article is written to show the relationship of medical illustration to hospital organization, the purpose a Visual Education Centre serves, and a short resume of the training necessary to render this service. It is hoped that it will stimulate constructive interest and the co-operation so necessary between medical men and artist as a means of developing Visual Education to the full.

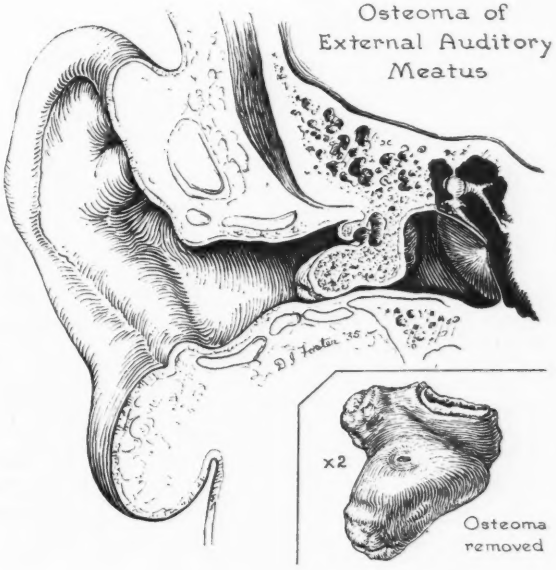
(Several of these illustrations are by members and former members of the Department.)

Fine Art and Camera Salon

A Salon of the pictorial art of physicians will be held at the Canadian Medical Association convention in Banff this June. There will be a combination of both photographic and "fine" art. Oil paintings, water colours and etchings, charcoal drawings, pastels and temperas will this year be combined with photography. It will be known as the "Canadian Physicians' Fine Art and Camera Salon". The sponsors, Frank W. Horner Limited, are prepared for a large exhibit.

Arrangements have been made to have all work judged by prominent artists, right on the scene at Banff, and the hanging of accepted pictures will take place concurrently with the convention. Presentation of plaques will be made by Dr. T. C. Routley, general secretary of the Canadian Medical Association. The plaques will be bas-reliefs of the head of Sir Frederick Banting, himself a noted artist, with a suitable inscription; they will be presented to the prize-winning doctors in the photographic and "fine art" field.

Entry forms for submitting pictures this exhibition have been mailed from Montreal to physicians throughout the country. Express charges on entries submitted will be paid both ways by the sponsors.



A fine example of line work by Miss Dorothy Foster which brings out the third dimensional factor.

C.H.C. Executive Meets

THE Executive Committee of the Canadian Hospital Council met at the Council headquarters in Toronto on April 25. In the absence of the President, Mr. Swanson, who was confined to his hospital through illness, Mr. R. Fraser Armstrong presided.

The new quarters of the Council were much admired by the Executive and it was noted that already the space is none too big for the staff of seven now carrying on the work of the Council.

The appointment of Dr. A. L. C. Gilday as treasurer was confirmed by formal resolution. Already Dr. Gilday has made his presence as treasurer felt by a very careful analysis of the business set up of the Council and by numerous recommendations designed to develop the most efficient methods of accounting. The report of Mr. Swanson's special committee to work out a program of financial support for the Council indicated much progress and a widespread desire on the part of the hospital associations and conferences to provide whatever funds are necessary to carry on the work.

Much discussion took place respecting the nursing situation in hospitals. It was noted with approval that Miss Jean Masten, Director of Nurses at the Hospital for Sick Children, Toronto, and retiring President of the R.N.A.O., has accepted the chairmanship of the Council Committee on Nursing and Nurse Education. The brief respecting nursing prepared by the Canadian Nurses Association for submission to the Council this spring was reviewed and the appointment of a joint study committee with that body to study the whole question of nurse education and hospital nursing was confirmed.

In an interim report Dr. O. C. Trainor reported progress in the working out of a basis of membership for hospital service plans in the Canadian Hospital Council.

In view of the fact that the constitution of the Council, except for minor changes, has not undergone thorough revision since the organization of the body in 1931, it was agreed that a subcommittee be set up to review the constitution of the Council and to make recommendations for consideration at the next general meeting which would be designed to make the Council conform to the present needs of the field.

Considerable discussion took place relative to the suggestion of the Department of Veterans' Affairs that the Council give further consideration to the basis of payment to hospitals for hospital care given to ex-service men and women. The hope of developing a uniform rate of payment across Canada does not seem very bright and is not entirely desirable. It was agreed that the basis of payment should be worked out on a provincial basis. The decision as to whether it would be on the basis of the going rate plus extras as already proposed by the D.V.A. and supported by the Council or on a classification basis should be determined by arrangement between the D.V.A. and the respective associations.

Progress to date in the considerations at Ottawa and Paris respecting the holding of a United Nations Medical Congress in Canada sometime in 1947 was reviewed. If such a congress be held, it was the opinion of the Executive that a hospital section would be desirable and it was agreed that the Canadian Hospital Council should be prepared to participate in such a program.

The interim reports of various committees were reviewed. It was noted with approval that the Accounting Committee proposes to meet in Winnipeg in October at the time of the Manitoba Institute on Hospital Administration.

Health insurance developments in Canada during the past year were noted. Although there is very little activity in the eastern provinces, the recent legislation passed in Saskatchewan and the activities developing in the other western provinces would indicate that health insurance is a very live issue in the west and will probably play a still more important part if the current Federal-Provincial negotiations reach a conclusion satisfactory to the implementation of the Federal proposals for health insurance. It was agreed that the Health Insurance Committee of the Canadian Hospital Council should be made up of the Executive Committee plus Judge Milton George of Morden, Manitoba, and Father Bertrand of Montreal.

The many inquiries of hospitals respecting Federal loans for the expansion of hospital facilities were reported. Unfortunately no definite action has been taken at Ottawa pending the results of the Federal-Provincial negotiations. The long delay in completing negotiations which would be satisfactory to the provinces and to the dominion has had the net result that in most instances any anticipated assistance from the provinces has been held up.

The editor of "The Canadian Hospital" and the manager, Mr. Charles A. Edwards, were pleased to report that the magazine is receiving steadily increasing support both from the hospital field and from the advertisers. Although there have been many printing difficulties, including the rationing of paper, the Journal is now well established and meeting the needs of the Council and its members.

A further study respecting the status of succession duties on bequests made to hospitals in wills was authorized. It was pointed out, however, that in the light of the present Federal-Provincial negotiations there may be considerable adjustments in succession duties in the next year or two.

The success of the joint sessions held in British Columbia and more recently in Alberta of committes on economics representing medical, hospital, nursing and dental organizations was considered to be such that this procedure could well be recommended to similar associations in other provinces.

The rising costs of drugs in hospitals was noted with concern. Statistics from representative hospitals were submitted. It was agreed that hospitals should be asked to note this particular item in their operating expenses, and if the increases seem to be abnormally large the administrator, the pharmacist and representatives of the medical staff might

(See next page)

The Necessity of Meeting
The Small Hospital Situation

Refresher Courses *for* *Medical Record Librarians*

By HARVEY AGNEW, M.D.,
Secretary, Canadian Hospital Council

IT is not my purpose at this time to review the available facilities for the training of medical librarians, or the opportunities for refresher or additional courses. Others, more closely in touch with the details of these courses, could review these developments to better advantage.

My approach to this subject is more that of the medical staff and the hospital administration. These groups are not so much concerned primarily with the technical details of providing adequate initial and post-graduate training as they are with the problem of obtaining an up-to-date and intelligent clinical records service and of having available sufficient personnel to meet the needs of an expanding field.

One has but to peruse the journals dealing with medical records (including your own excellent journal, "The Bulletin", of the Canadian Association of Medical Record Librarians) to realize how much there is to know in this field and how much progress is being made from year to year. Any profession in which its members can put their books and journals behind them and depend on their initial training for guidance is a dead and drifting profession. Actually, it has no right to be called a profession. President Hutchins of Chicago has stated that the sheepskin is given at graduation to cover the intellectual nakedness of the university graduate. In other words study must be continued all through one's career. If the medical record librarian is to keep abreast of her science and meet the increasing demands of one of the more important factors in furthering medical progress, she most keep in close touch with the latest developments in the field.

This may be accomplished in part by extensive reading; some of this may seem repetitive, but always there will be found a new idea. Attendance at meetings such as this will prove invaluable; not only through the addresses do you glean new ideas, but through the helpful tête-a-tête conversations with others struggling with the same problems. To visit the records departments in other hospitals is time well spent. All of these help. The difficulty, however, is that all too often the information obtained is not complete or co-ordinated. Here the extension or refresher course can help.

We find these courses exceedingly valuable in medicine and in nursing, as well as in other professions. They should be equally helpful to you.

Fields of Instruction

One gets the impression that many of the medical records departments could be better organized. A number of our medical record librarians have not had the advantage of much, if any, formal training and would welcome added opportunities. However, in many instances it is not the librarian who should be attending the course; it is her hospital administrator who may not see the way clear to give her proper facilities and the medical staff who do not give full co-operation.

Perhaps the greatest need, from the clinicians' viewpoint, is further instruction in the use of the Standard Nomenclature. Much progress has been made in its adoption during the past decade. This is pleasing indeed for the long standing confusion in terminology due to the evolutionary process by which pathology has been interpreted and classified in various countries has made it exceedingly difficult for many generations of puzzled medical students and has definitely delayed the large scale compilation of comparable medical data. It may take some years for this terminology to become general in our journal articles and in text books but eventually such should be the case.

However, it is not as easy a system to pick up alone as some of the earlier ones. The doctors often are willing to change over in the hospital, but they do depend upon the medical record librarian to help them understand the system and make this change. Unless she understands it thoroughly herself, she will have trouble making it clear to the doctors and they will quickly lose interest in the custom, each man reverting to his own distinctly hybrid terminology.

Helping the Small Hospital

Our biggest clinical records problems are in the small hospitals. I have in mind the smaller hospital of 25 to 35 beds. Here in Canada we have 248 active public hospitals betweeen 15 and 50 beds capacity. There is often not enough work to warrant the appointment of a fully qualified medical record librarian and

Address, The Institute of Medical Record Librarians, held under the auspices of the Canadian Association of Medical Record Librarians at St. Michael's Hospital, Oct. 26/45.

Executive Meeting

(Concluded from preceding page)

have a conference to consider the causes and possible means of reducing this item.

The lack of adequate machinery by which hospitals could know of and purchase surgical and general hospital equipment from the War Assets Corporation was deplored. Developments to date were reviewed.

someone less qualified must take on the work, frequently along with other duties. The doctors do not analyze the records for scientific studies as frequently as they do in larger hospitals, thus depriving the librarian of one of the chief delights of the work.

To really be of benefit to the field as a whole, refresher courses should be directed to help these librarians.

Manitoba Takes Lead

In this connection the spreading use of the Standard Nomenclature raises the question of how knowledge concerning its use is to be given to those in charge of records in the smaller hospitals. As an example, last year the Manitoba Hospital Commission recommended among other valuable proposals "that the 'Standard Nomenclature of Diseases and Operations' be adopted by the Manitoba Hospital Council which shall be compulsory for all hospitals". This action was very pleasing to those of us who have been looking for just such governmental action to stimulate hospitals towards this objective. It is a distinctly progressive step. I would not be suprised to see a similar regulation adopted as time goes on in the other provinces.

But they are now faced in Manitoba with the necessity of providing training for those who will keep the records. It is not feasible for all of the medical record librarians in the province who are not fully familiar with the system to take a long course of training; for that matter, many of the smaller hospitals, as in other provinces, do not have a medical record librarian at all. There is need in various parts of the country for the provision of intensive courses of training for those librarians now holding positions as medical record librarians and who wish to improve their knowledge of this particular system—or any other of the many phases of the work.

This brings up the question, How far should your profession go in "half-training", as it were, a number of people, some of whom may not have the educational background, or may not have intention to take sufficient training, to qualify for membership in your organization?"

This is a question which crops up in many professions—medical, nursing, dietetic, laboratory, etc. In our efforts to improve the standards in our special groups we are apt to shut the door to all but those who can meet rigid and ever-increasing standards. Almost invariably we endeavour to set them at higher levels than we ourselves had to meet.

Personally, I am all for high standards and strongly support their trends but, at the risk of being misunderstood, I do feel that there are times when, if the public weal is to be served, we must make efforts to impart a share at least of our knowledge to others not so well qualified. Many hospitals cannot now and never will be able to afford a properly trained and registered medical record librarian; the best they can afford is someone perhaps with but partial if any training but with good native ability and a willingness to learn. Remember that over 60 per cent of our active public hospitals have less than 50 beds. It is better that this type of person be given a short albeit incomplete training in the basic principles of keeping medical records rather than be allowed to flounder without any guidance whatsoever. Extension courses in universities are not primarily for their graduates but for other groups in society.

This action on your part would not mean the admission of inadequately trained people to your organization. That would still be a registry of fully trained individuals upon whom would rest the hallmark of approval of your official association. Universities do not give degrees to those taking their extension courses. By extending facilities to the librarians in smaller hospitals, you are really advancing, not retarding, the advancement of medical records in general.

History Taking

Also, a new situation is developing in hospitals. Under the stimulus of the American College of Surgeons and now of provincial regulations, more and more hospitals are keeping better records. Under the likely

(Concluded on page 86)

How Do They Train 'em That Way in Argentina?

I'm sorry, madame, tomorrow you can continue with your confinement; I must go now to complete my clinical charts.

—By Roberto in "Mundo Hospitalario."

Hospital Lawns and Pathways

Their Care and Maintenance

ALEX MONTEITH, Toronto

ONE of the principle worries of those responsible for the grounds and gardens of our public hospitals has always been the scourge of weeds. Perhaps at no time in the history of this country has that scourge been a greater menace than it is today, for after many years of war the weed growths have made such headway that the resulting loss runs into millions of dollars. Thus it occasions little surprise to hear that the Minister of Agriculture for Ontario, the Hon. T. L. Kennedy, has planned a vigorous and active campaign against weeds this year, in which spraying machines, chemicals and other methods will be used; the campaign will be supported by some four hundred and fifty inspectors. The "Battle of Weeds" to be waged in Ontario will also be waged throughout Canada.

Department experts have estimated that weeds cost Ontario farmers alone over $20,000,000 annually; imagine what that means in terms of lost bushels of wheat, unharvested flax and losses in expensive crops such as peas and onions, which have to compete for air and moisture with parasitical plants growing unchecked in their midst. Think, too, of the labour costs that go annually to rid gardens and golf courses of plantains and dandelions, country cottages and camps of poison ivy and ragweed, and farm lands of mustard and thistle. It is small wonder that after six years of wartime man-power shortage and lack of material, these weeds today exact such a heavy toll.

2, 4-D

Inevitably after periods of war there appear many benefits discovered by scientists either as a direct outcome of military requirements or else by accident. One of the first of these finds during World War II is a chemical herbicide which possesses the unique property of attacking certain weeds selectively, leaving other plants and crops totally unaffected; by using this new chemical the agriculturist or gardener can, by simple overall treatment of a patch of ground, rid the soil once and for all of most of the noxious growths. This modern herbicide is a triethanolamine salt of dichlorophen oxyacetic acid, commonly known as "2, 4-D," and it has been heralded by the press as the atomic bomb of the horticultural world. It selects its victims and systematically kills them, destroying weeds of the plantain family, but leaving grasses unharmed. Poison ivy, ragweed—that prolific generator of hay fever—mustard and morning glory are killed outright to their roots, while wheat, oats, barley and lawn grass are immune.

No longer is it necessary to go through the backbreaking business of getting down on hands and knees to uproot weeds. Gone, too, are the days when the beauty of the green lawn need be sullied by armies of golden dandelions. Today one brief spraying with this new chemical will rid the soil for good of these pests.

Value to Hospitals

To our hospitals the advent of 2, 4-D is of particular importance. Today the trend, especially in the case of the convalescent hospitals, is to migrate farther and farther afield into the country areas, and also to take in a larger acreage of ground for treatment, recreational and ornamental purposes. The need for air, and plenty of it, is being stressed more and more as technical develop-

At St. Paul's Hospital, Vancouver.

ments both in building and in planning progress. This tendency brings in its train an accompanying problem which is overlooked, perhaps, in a great many cases, but which can be solved very largely by the scientist with his new discoveries; the trouble is chiefly that larger areas of ground, particularly in rural districts, are more easily and frequently affected by wind-borne seedlings of the noxious and irritant weeds.

Farm land as a whole is riddled with weed growth. Much of it will be treated this year and in the years which lie ahead, but even with the best intentions in the world and the most vigorous pursuit of the campaign, it will be a long time before the weed menace is reduced to fully controllable proportions. Apart from the actual weeding of the soil itself, there are the attendant difficulties of weed-infested seedings, the perennials which remain hidden in the ground, and lazy owners who will not take time or trouble to clean up their land. From such areas will come the air-borne troops of the weed armies, to land without compunction on cultivated land and garden alike; the larger the hospital ground is, just so in proportion will it receive its quota of dandelions, mustard and other parasites. Added to these pests there are the hay fever generators, notably ragweed; this plant is definitely killed by 2, 4-D and with its eradication goes the chief offender.

Besides the assistance which can be given from the health angle by the use of modern herbicides, there is the question of the appearance and ornamental attractiveness of hospital grounds and lawns. The cost of maintaining these in first-class condition, not merely from the viewpoint of the floral displays, but the clearing of the grass and paths of weeds, has always been a fairly heavy item of expenditure. Labour costs have played a large part in this expense and the introduction of chemical weed control will reduce this figure considerably. By using highly concentrated, double-strength liquid type of 2, 4-D now available in Canada, it is possible to treat an acre of ground for less than $5.00, and the cost of spraying or applying it over the area to be treated is not high. Where a hospital already owns a spraying apparatus the total cost will be the initial outlay for chemicals plus a small addition for the operator's time. Even if no equipment is owned, it is a relatively inexpensive matter to let the contract to one of the numerous spraying companies, who treat a lawn as easily as they do an orchard. It is advisable at this stage, however, to make sure that the heavy concentrated liquid type of 2, 4-D spray is used rather than the more expensive powder; for that reason it would be wise to purchase supplies direct from manufacturers for the time being, until the chemical enjoys a wider usage.

Precautions Needed

But the blessings of 2, 4-D are not altogether unmixed. Although discriminating in its choice, 2, 4-D includes among its list of victims all flowers and most vegetables. It spells death to any ornamental shrub on the leaves of which the spray falls, and if even a minute particle of the chemical finds its way onto a fruit tree in bloom, the effects will be immediate and ruthless. Care must be taken in using the spray apparatus or watering can, and no drop of the concentrate must be left unrinsed in the equipment which has been used. With care 2, 4-D can be an unmitigated blessing, but in the hand of a careless husbandman it can be a veritable demon of destruction.

Alongside this wartime discovery have come other weed killing agents in new forms. Before the war many good killers existed for cleaning out ditches and fences, clearing weeds from garden paths and from cracks between the flagstones in crazy pavements. Unfortunately these pre-war killers each had some drawback—the ones which did not employ an arsenite used some other chemical which certainly killed the weeds but made the spray inflamable; sometimes another agent was used which caused corrosion in the spraying equipment. There was the old tried-and-true business of spraying with fuel oil, but at best this was a messy way of doing things, and not a very happy expedient where the risk of fire was high. Many brands were heavily poisonous. Generally speaking, there was a crying need for some new chemical substance which would do its job without harbouring these disadvantages. This need was especially great in the case of hospitals and schools. Now there has appeared a totally new chemical which combines with water in incredibly small quantities to give all the results demanded. This, together with 2, 4-D, will solve many of the problems encountered by hospital groundsmen.

Those who look after the lawns and pathways of our great hospitals may hail these new discoveries as a great labour-saving find. In turning to the benefits offered them by the scientists and agricultural chemists, they will be assisting the Dominion in its drive to rid the soil of Canada of one of the worst thieves of our national income.

Panel Heating

(From an article by Karel R. Rybka in the Journal of the Royal Architectural Institute of Canada).

THE prominence of panel heating — usually mistermed "radiant" heating—in the recent American engineering literature gives it the appearance of a new and unheard-of development and could lead to the impression that it is the cureall for heating ills. Its more than forty-year struggle first for survival and later for a decent existence seems forgotten and little seems to be known of its many designs and patterns which have been developed over the years; through ignorance, some of its earlier developments are being hailed as the newest and latest, and sometimes even future aspects of the science of heating. There belongs the oft-heard statement that in the near future panel heating may also serve for summer cooling, although it was so applied a decade ago in Switzerland and Czechoslovakia or the expression of hope that some bright lad may soon develop the use of panel heating coils as an integral part of the reinforcement of concrete structures, though they were so used in 1933 in a large Dutch institution, and shortly afterwards the Czechoslovak Department of Public Works published regulations for the use of heating tubes as concrete reinforcement.

Unless the architect or engineer knows well the history of this controversial subject, he is at a loss to extract from the maze of contradictory information those grains of truth that will permit him to apply correctly its many available patterns. Although panel heating is here to stay, it will not replace many of the recent developments in heating and ventilation and particularly in air conditioning, but it will contribute to better living and working comfort where applied after careful consideration of it special merits and limitations.

Physiological Concepts

The indoors environments for human occupancy are intended to ensure the measure of heat losses from the human body required for comfort and health; this heat loss must be distributed reasonably evenly over the entire body. Overheating one and chilling another part of the body will be detrimental to health, even if the total heat transfer from the body corresponds to the required metabolic rate. The human body has, however, considerable regulative powers which will usually correct small discrepancies in heat transfer from its diverse parts.

The heat lost indoors by the average human body at rest, by evaporation, convection, conductance and radiation is approximately 400 BTU/h. For diverse degrees of activity the rate of heat loss is higher and considerable data are available on this subject. Heating designs are readily corrected for these variations by a slight reduction in temperature of the working space.

The loss by evaporation at comfortable indoors conditions averages 80 BTU/h which leaves about 320 BTU/h for loss by convection, conductance and by radiation. As long as the total rate of transfer is maintained, it is immaterial what proportion of this heat is transferred by radiation.

Many panel heating experts still obscure their calculations by complicated formulae involving the fourth power of the absolute temperatures, though within the applicable temperature range from 50°F. to 120°F. heat transfer by radiation is closely proportionate to the difference in temperature of the bodies; for the so-called black body 1.05 BTU per square foot per hour per degree F. will give good results and will reduce for usual clothing or walls and floor coverings to slightly less than 1.0 BTU per sq. ft. per hour per degree F. Similarly, the heat transfer from the human body by convection in reasonable still air and usual room temperatures will resolve itself — regardless of the complicated convection formulae and their factional powers of temperatures and mean diameters—to a constant value of nearly 0.70 BTU per sq. ft. per hour per degree F.

The mean surface temperature of the clothed human body has been variously estimated from 75°F. in England, to between 83°F. and 86°F. on this continent. The surface of the average person exposed to radiation is estimated at 15.5 sq. ft. and that exposed to convection 19.5 sq. ft.

Fundamental Design Data

From the foregoing it is easily computed that, with still air and a mean wall temperature of 83°F., which stops heat transfer from the human body by radiation, an air temperature of about 59°F. would ensure the required total heat loss of 320 BTU/h per person by convection only, whereas with 83°F. air temperature, which stops transfer by convection, about 61°F. Mean wall temperature would achieve the same result by radiation only. Similarly to these extreme sets of values it is easy to establish corresponding air and wall temperatures for any intermediate condition. (This mean wall temperature must include an allowance for the radiation from the heating unit.)

These considerations prove that the old-fashioned living and working space, with its limited outside walls, would ensure satisfactory com-

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Karel R. Rybka, Mechanical and Electrical Engineer, is a graduate of Prague and was awarded a Doctor of Science Degree by that university while on a visit there in 1937. He has been in Canada since 1928 and was connected with the construction of several large buildings in Toronto. He is a member of the Engineering Institute of Canada and the Provincial associations of professional engineers in both Ontario and Quebec.

fort conditions with an air temperature close to 71°F., as the mean wall temperature (also resoundingly called mean radiant temperature or M. R. T.) would be inevitably close to 71°F. And conversely, in panel heated spaces with reasonably substantial walls and well insulated windows, a mean wall temperature of 73° to 75°F. will ensue, requiring for comfort an air temperature of 67° to 69°F.

This immediately leads to the final conclusion that the simple heat loss computations employed for "radiator" heating are fully applicable to panel heating, as the indoors temperatures used in either form of heating are nearly identical. It remains only to select a heating surface capable of supplying to the space the total amount of heat required to offset the calculated heat losses.

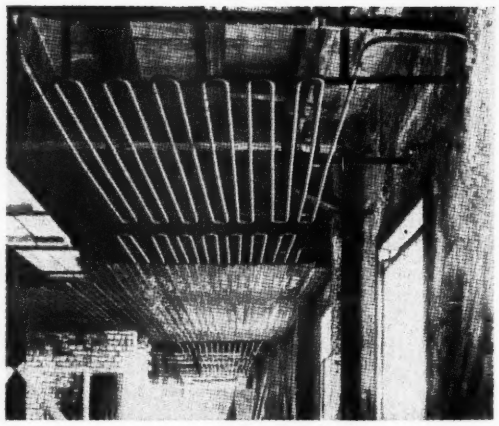
Care must be taken to eliminate excessive temperatures, particularly if panels are installed in floors. Some floor panels installed in Europe at the turn of this century have hampered the acceptance of panel heating there for a considerable time. They employed floor temperatures which exceeded 85°F. and invariably led to sore feet and expensive alterations. For wall and low ceiling panels in rooms of average height, 120°F. should be considered the maximum permissible temperature for comfort, though in high rooms considerably higher temperatures may be allowed. ("Radiators" in similar positions use temperatures over 200°F., but their influence is restricted by limited radiating area.)

Designs and Types of Heating Panels

The best known type of heating panel consists of pipe coils or pipe grids placed either in the floors, walls or ceilings, and through which warm water is circulated.

Another panel design is a copy of the original methods used by the Romans some two thousand years ago and consists of ducts or chimneys in walls and floors through which heated air is being circulated. They are built mostly of hollow clay tiles placed end to end. Sometimes the ducts terminate with air inlets into the room, to give supplementary air heating.

In some installations steam or high temperature hot water is carried through pipes which in turn are located in ducts in the floors or walls, etc. A very early pattern of this heating form was used about 1900 in the New York Lying-in Hospital and consisted of steam pipe coils behind smooth steel plate enclosures and placed along outside walls and under windows. Such heating panels are kept at low temperature by the air space between pipe and inside surface of enclosing duct. Control of heat supply is obtained by changing the rate of flow, or the temperature of the heating medium similarly to "radiator" heating. Diverse improvements were later introduced, many of which were intended only to circumvent patents granted for panel heating, such as fins attached to high temperature pipes and placed parallel to and partly in contact with the inside face of the duct surface, and designed to allow wider spacing of pipes or to reduce the extent of ductwork and piping.



Panel coils in course of erection in a suspended ceiling. When enclosed by the completed ceiling, these coils provide no lodging place for dust or dirt as is the case with radiators or grills. This is an important feature in hospitals.

The desire for creating accessible and inexpensive panels led in their day to smooth faced steel plate or cast iron radiators either with or without convection space on the back, which often substituted for wainscotting. This pattern was particularly favoured in commercial and industrial plants. Further developments of this pattern led to strip heaters and to metal baseboards through which hot water or steam is circulated; similar equipment has long been used occasionally to heat pews in churches, and also as strip heating in diverse plants.

Of some interest in industry are electric panel systems, with heating elements in conduits or ducts laid in floors or ceilings; the clearance around the elements permits use of fairly high temperature. Other types use wide strips of wire mesh imbedded in floors or ceilings and heated by low tension currents supplied from a special transformer. Electric panels have a future where no heat need be supplied during the working hours, as they would operate outside of the work day on very cheap power rates.

Fuel Costs of Panel Heating

The proponents of panel heating are claiming considerable reduction in fuel consumption against other heating forms, and often quote 30 per cent and more in savings. At first it was assumed—and many supposedly well-informed people believe even now that this is due to the lower air temperature. The explanation is rather weak, as this heating is based on higher surface temperatures of walls and floors and it is not the air temperature but the surface temperature of a wall which is determining the extent of its heat losses. It is self-evident that heating panels, if installed in outside walls, in floors on ground, or in roofs will increase, rather than reduce, heat losses of buildings unless their back surfaces are heavily insulated.

In some instances proof of savings by a comparison of fuel costs has been claimed under supposedly identical conditions, except for the type of heating. The only reasonably comprehensive report of this kind pertains to a school in Copenhagen and though about ten years old, is still being quoted avidly by most exponents of panel heating; however, upon close examination, it is found that during the tests the radiator-

heated portions of the system were manually controlled, whereas the flow temperature of the panel heating was thermostatically regulated. And it is a known fact that even a simple automatic heating control inevitably either effects considerable fuel savings or better comfort conditions than a manually controlled system. Other such comparisons were based on buildings of an entirely different construction where the expected differences were calculated and it was then proven that in actual practice the spread was much wider. In the last twenty years no irrefutable proof of actual fuel savings has been published.

Until exact and unimpeachable results prove the contention of the large savings, the only savings that could be expected in practice are those which usually accompany any form of modernization, and invariably can be ascribed to better control of heating or to better building construction; in addition, the negligible increase in boiler efficiency—if the boiler supplies directly the desired water temperature—and the slight reduction in heat losses of the supply and return pipes due to lower surface temperature, smaller pipe size and protected location of pipes (with "radiator" heating the piping is in outside walls, with panel systems usually in partitions) may ensure some added economy.

All these benefits are partially offset by the experience that the fuel consumption of panel heating systems during reduced temperature periods, viz., over week-ends and holidays, is higher than that of equal "radiator" heated buildings.

Advantages of Panel Heating

Apart from any controversial claims of operating savings, a well designed and properly installed panel heating system has many distinct advantages. It is fully concealed and eliminates obstructions and loss of usable space and permits placing heat supply where it is needed.

One of the most important features is a more even distribution of air temperature both horizontally and vertically throughout the heated space, than is usually obtained from "radiators" or any other form of heating. In spaces with floors on ground or in rooms directly under a low roof, the floor, respectively the ceiling, is usually warmer with panel heating than with any other heating form; this also applies to outside walls except that "radiators" if placed under windows, blanket to a higher degree the cold window surfaces. These characteristics of panel heating render it more conducive to health, both by uniform heat transfer from the human body and by reduced air currents and drafts. The reduced air temperatures in panel-heated spaces permit correspondingly higher relative humidities without condensation on windows and other cold surfaces. Furthermore, the low temperatures of panels eliminate entirely the scorching of dust which is the objectionable feature of high-temperature hot water and steam-heated radiators, as it charges the air with small quantities of irritant vapours and fumes.

The large heating surfaces of panel systems render them also well suited to summer cooling, but will be fully satisfactory for it only where the panels are located in ceilings or fairly high in walls. Floor panels increase the discomfort from direct contact of the human body with the cooling surface and have the tendency to stratify the cooled air in the lower levels of the room. The local climate must also be considered, as high relative humidities of the air will inevitably lead to condensation and added maintenance. Another disadvantage encountered with floor panels used for cooling would be the need to protect them carefully against solar radiation.

Disadvantages of Panel Heating

The chief objection to panel heating in industrial buildings is at present its high cost, when compared with the customary heating forms such as unit heaters, central fan heating systems and others. In some instances the possible omission of ventilation systems for exhausting vapours, or of supply ventilating systems, necessary to overcome formation of fog in the building, may change the comparison to favour the panel heating. In most cases, however, it will be necessary to evaluate such intangibles as improvement in health of employees and incidental improvement in absenteeism, reduction in maintenance costs and repairs, reduced spoilage of goods, etc.

Another word of caution should not be omitted. In plants where noxious or obnoxious fumes, dust and gases are generated in the course of the processes, panel heating may also lose many of its advantages by the rapid changes of air required for purification of the indoors atmosphere.

Future Trends

In view of the considerable age of panel heating—it antedates many of the developments in heating and air conditioning which have far outdistanced it—no surprising developments may be expected from it in the near future. The designer has a sufficiently wide variety of patterns to choose from and will hardly worry about any others. The most promis-

(Concluded on page 82)

L. O. Bradley, M.D.

Assistant to the Superintendent, Royal Alexandra Hospital, Edmonton.

Dr. L. O. Bradley has been named Assistant to the Superintendent and Senior Resident at the Royal Alexandra Hospital. Born in Neudorf, Saskatchewan, Dr. Bradley was graduated in medicine from the University of Alberta in 1938. After spending his internship at the Royal Alexandra, he became a Fellow in paediatrics at the University of Minnesota Hospitals in Minneapolis. He enlisted in the R.C.A.F. medical branch in September, 1940, and was variously Unit Medical Officer, Senior Medical Officer and Commanding Officer of a convalescent hospital. He was retired in November 1945 with the rank of Squadron Leader.

Obiter Dicta

Rising Drug Costs

AT a recent meeting of the Toronto Hospital Council, a discussion on the steadily rising cost of hospital operation revealed that a number of the hospitals are quite concerned over the mounting costs of drugs. These have shown a steep rise during the past few years, a typical increase being that reported by one of the hospitals represented:

1941	$28,912	
1942	$30,500	
1943	$31,675	
1944	$35,833	
1945	$47,297	
1946	$60,000	(estimated on the basis of costs to date)

A still larger hospital reported a doubling of its costs in the same period, the indications being that its 1946 cost will run $90,000 to $100,000. Other hospitals reported comparable increases and we know there has been a similar experience in other centres in Canada. During this period hospital occupancy has remained practically constant—at the maximum.

What are the causative factors? Apparently a major cause is the increasing, almost indiscriminate use of penicillin. The *New England Journal of Medicine* stated recently that one Boston hospital had used in six months the equivalent of the entire world production in 1944. Enough penicillin was used there in one day to meet the needs of the hospital's patients for three months. Many uses for penicillin are being found and, in this experimental period, there is justification for extensive clinical trials and for massive doses. But it would seem that much experimentation or a "last resort" type of therapy are being done which a perusal of the great volume of literature on penicillin would indicate is a complete waste of penicillin and of somebody's hard-earned dollars. In some of the forms offered, little, if any, of the penicillin content is utilized. Moreover, by unnecessarily developing a personal resistance to the effects of penicillin, or by helping to develop penicillin-resistant organisms, the patient and the race as a whole are not receiving much permanent benefit by a too-free use of this drug.

More hospitals are using glucose in large quantities. This costs money, whether purchased ready to use or prepared in the hospital. One pharmacist in a large hospital states that the cost per bottle has gone up since they stopped making their own, but the doctors do like the easy administration of the purchased products. Sulpha drugs were a costly problem a few years ago but are not a serious factor now. When the writer was in practice, only the really restless got a sedative—and then usually an inexpensive bromide. Now in many hospitals practically everyone must have a hypnotic every night and, always, one of the expensive trade-name capsules or tablets is used. A staff doctor said this week, "For years we found inexpensive strychnine by mouth or needle quite adequate for stimulation; why must our interns now order ampoules of coramine on every occasion?"

Another factor may be the increased use of vitamins under trade names. One hospital pharmacist has had to stock fifteen different B-complex tablets and fifteen liquid preparations of the same B-complex. The same hospital stocks twenty-one (21) different kinds of multiple vitamin preparations. The vitamins alone take up eight pages of the stock book. One Toronto hospital stocks thirty different iron preparations. This is utterly ridiculous and indicates the need for standard pharmaceutical preparations. The new Formulary prepared by a special commitee of the Canadian Medical Association will soon be off the press and should give the medical staffs and the pharmacists of hospitals an opportunity to tighten up on these lax practices and thus effect distinct economies. Certainly these tremendous jumps in drug costs cannot go on and warrant the setting up of a special committee in each hospital to study the factors and work out the best means of control.

Health and Security Measures in Great Britain

THE national insurance and national health services measures of the Labour government in Great Britain are of unusual significance to us here, especially as it has so often happened in the past that developments there have been followed by a considerable degree of duplication here. These measures may also have considerable influence on the fortunes of the compulsory health legislation now being proposed at Washington.

It should be noted that there are two measures, evolutionary products of the old panel health insurance, the "dole", the Beveridge proposals and the Coalition's "White Paper". The *national insurance* measure is a social security one, providing, among other benefits, sickness benefits, maternity grants and allowances, unemployment benefits, old age pensions, widows' pensions and allowances, guardian's and dependents' allowances and death grants. The *national health services* measure

provides medical and hospital care including specialist care in hospitals, midwifery, dental care, home nursing, free spectacles, drugs, ambulance service and certain public health undertakings.

A commendable feature of the national insurance measure is that it is *contributory* in part. A working man contributes 92 cents a week and his employer contributes 78 cents on his behalf. Self-employed individuals contribute $1.15 a week. People will be less likely to abuse a plan into which they pay directly. Another safeguard is that there will be no cash benefit for the first three days of sickness or unemployment. The estimated costs seem staggering; some $1,808,000,000 will be required in 1948, of which only $472,000,000 (about one quarter) will be raised by these contributions. By 1978 the cost may rise to $2,996,000,000, of which $1,352,000,000 may need to come from general taxes.

More controversy is taking place over the national health services bill. A feature which is revolutionary rather than evolutionary is the proposed expropriation of all voluntary and municipal hospitals by the state. Some of the teaching hospitals are to be excepted. The administration will be turned over to new regional hospital boards and the staffs of the hospitals, including the nurses and paid physicians, will become employees of the regional boards. So far less opposition has been noted than would be the case in this country. The prevalent custom of buying practices will be prohibited. This is being opposed, although the compensation offered would seem to be greater than has been the usual rate charged for practices. Medical men are largely in opposition to the salary features of the measure as they affect medical practice, although the actual contentions of the profession are not being clearly interpreted in the lay press. There is much controversy over the old question of lay versus medical administration, now brought sharply to the fore! Here, however, where it is generally recognized that both have a place and that it would be a loss to exclude either group, it is difficult to understand why there should be so much heat over the subject.

With respect to public health provisions, it is to be regretted that vaccination, which has been compulsory since 1853, is to become optional. Presumably this is a sop to that ignorant but vociferous little group who forget the days when every third person still alive in London was pock-marked, not to mention the many thousands underground.

Aid in Case of Disability

STRONG support was given in the House of Commons last month to Mr. Lionel Bertrand's motion to provide financial aid for those handicapped by disability. Mr. Bertrand's motion reads:

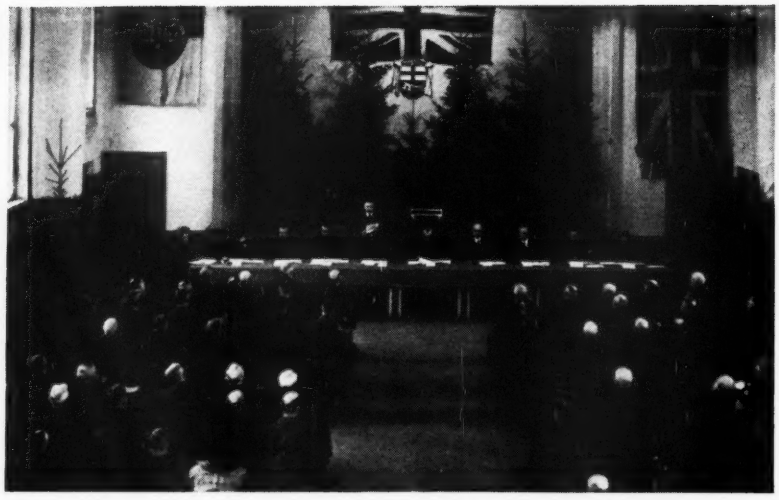
That, in the opinion of this house, the government should take into consideration the advisability of including in their social security programme a system of allowances to every person, without any income or means of support, who, by reason of an injury, accident or congenital infirmity, is at a disadvantage in seeking or obtaining employment, or incapable of providing for his subsistence, and whose age prevents him from benefitting by the social security legislation now in force.

The benefits resulting from family allowances and payments to indigent mothers, the blind and the aged should be extended, in the opinion of Mr. Bertrand, to that large group of invalids and cripples over sixteen and under seventy years of age. He pointed out that, in this age of mechanisation, the person without strong arms, strong legs and powerful eyesight has great trouble making a living and frequently must resort to public charity. Mr. Coldwell urged the same consideration for arthritics and those with incurable conditions like disseminated sclerosis as for the blind and the aged. Said Eugène Marquis: "Ce n'est pas là du socialisme, ce sont des lois sociales, adoptées dans le but de remédier à certaines anomalies et à certaines misères de la société." Mrs. Strum pointed out that these people need assistance to pay rent and to buy clothing, food and perhaps drugs and appliances. They need medical care and should be given special training. Money should be available for research. Pitiful tales were told of specific instances by various members of the House, including Dr. Gauthier and Dr. Blair, the former empasizing what a help this assistance would be to the hospitals.

In expressing sympathy with the proposal, the Hon. Brooke Claxton noted that the debate had been singularly free of detail as to how the plan could be worked out and financed. Two classes of people might be included—those who are normally employed but suffer accident or sickness and those who are totally and permanently incapacitated. In some countries the former group are now covered by contributary sickness insurance. Invalidity benefits are particularly hard to administer. "In a time of high employment there is a much greater tendency for everyone to use his capacities in a useful fashion than during a time of relatively low employment, when there is a great tendency for people to discover reasons which prevent them from working." A measure like this paying something like $5.00 a week might mean an annual outlay of as much as $100,000,000.

Canada is now paying tremendous sums for social security. Unemployment payments for February of this year amounted to $5,903,000 and family allowances for the same month totalled $19,690,000. The Dominion's share of old age pensions and benefits for veterans added another $42,382,000. Gratuities and re-establishment and rehabilitation benefits totalled $6,222,000. With another $8,000,000 for dependents, a total was spent in February, 1946, of $89,000,000—which works out at the rate of *one billion dollars a year!* Mr. Claxton rightly pointed out that if we add still further to our load, "there will be a steady decrease in initiative, in the willingness of the people to take risks and to work, which cannot avoid having a disastrous effect on the value of our money and on our ability to maintain the kind of economy we want."

Mr. Claxton made it clear that the order of priority of various social security measures must be considered, as "it is not possible in any country to introduce a complete system of social security measures all at once". The health insurance proposals advanced by the Government will be recognized as having priority over this present proposal. This would seem to be a logical viewpoint, despite the desirability of providing help to these unfortunate invalids.



Gordon Friesen as Military Governor of Kreis Brilon speaking in German at the Inauguration of the "Kreistag". He is due to return to Canada this month.

S/L Gordon Friesen Serves as Military Governor

A LETTER from Squadron-Leader Gordon Friesen, formerely on the Staff of Saskatoon City Hospital and, prior to enlistment, superintendent of the Belleville General Hospital, indicates that he has had a most interesting experience since going overseas with the R.C.A.F. His letter reads in part:

"The most interesting time of my service career has been since I arrived in Germany. I left England on April 1st, 1945, and my first job in Mil Gov was in Hann.-Munden (near Kassel.) We arrived a few days after the Americans had occupied this area and, obviously, considerable exictement prevailed. The functions for which I was responsible at that time were Public Safety, Displaced Persons, Religion and Education and Public Health. The D.P. camp consisted of approximately 6,000 people of all nationalities, and the difficulties encountered in maintaining law and order were tremendous. I had to investigate cases of murder, rape, looting and various other types of incidents. After leaving H-Munden I received the appointment of Military Governor of Kreis Brilon, in the province of Westphalia, which has approximately 85,000 inhabitants.

"The situation in which I now find myself is really fantastic. There are five officers in the detachment and about nine other ranks. My duties are numerous and varied. It is my responsibility to institute youth-organizations, trade unions, etc., as well as to approve the appointments of politicians, civil servants and officials in their various trades and professions. It was particularly interesting to organize the local government, based on the democratic principles existing in the British Empire. This is very foreign to the Germans, as you can imagine, after twelve years of dictatorship. It has been necessary for me to deliver addresses in German on various occasions.

Yours sincerely,
"Gordon A. Friesen",
S/L., R.C.A.F.,
Cond. 615, Mil. Gov. Det."

(A copy of S/L. Friesen's address at the Inauguration of the "Kreistag" was enclosed).

Cardiac Research Getting Under Way

Colonel Francis R. Dieuaide, until recently Chief of Tropical Disease Treatment Branch of the Surgeon General's Office in Washington, has been named Scientific Director of the Life Insurance Medical Research Fund. Before joining the Medical Corps, Dr. Dieuaide was Clinical Professor of Medicine at the Harvard Medical School.

The Life Insurance Medical Research Fund was established last year to make grants to universities and medical schools for research on diseases of the heart and related diseases. The Fund plans to make grants of more than $3,000,000 for this purpose over the next five years. A total of 147 life insurance companies in the United States and Canada are supporting the Fund.

The Fund has approved further grants totalling $310,000 in support of research work on diseases of the heart and related diseases at 27 institutions in the two countries. This action brings the total of grants made since the Fund was organized to $436,000. Other applications are still under consideration.

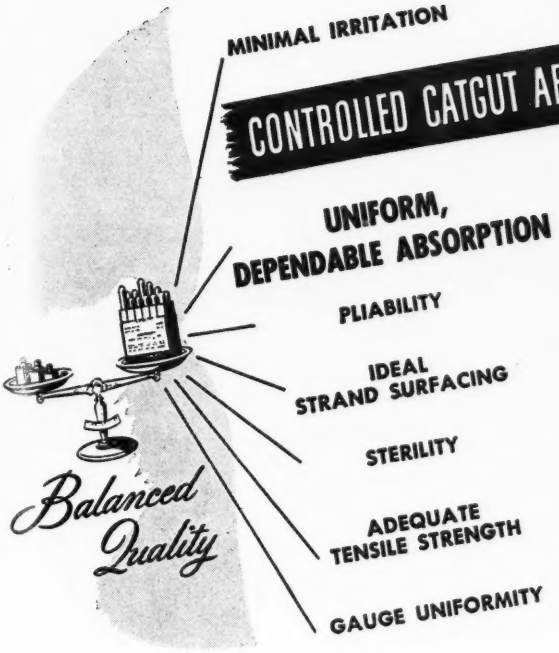
The new grants made by the Fund represent a total of 34 specific allocations to institutions and research workers. Five of the grants are for studies on arteriosclerosis and coronary diseases, four for studies on hypertension, three for studies on kidney diseases, and five for research work on rheumatic fever.

One of these grants has been made to McGill University, Montreal, where research thus financed is being carried out by Drs. Charles P. Leblond and Sydney M. Friedman.

Another Hospital Loses Narcotics

The entire stock of narcotics of the Strathroy (Ont.) General Hospital, valued in excess of $500.00, was stolen on a recent Sunday night.

The thief or thieves, continuing a wave of similar thefts which have swept western Ontario in recent weeks, boldly entered the hospital, ripped a steel locker bolted to a shelf in the dispensary from its fastenings. A member of the R.C.M.P. narcotic squad from London is in charge of the investigation.



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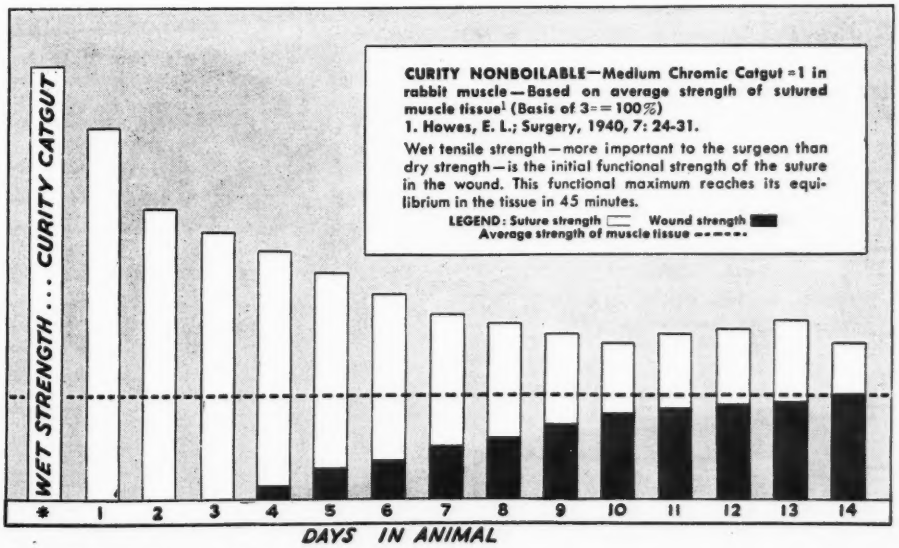

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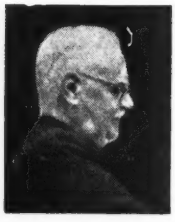


C. E. A. Bedwell

Dear Mr. Editor:

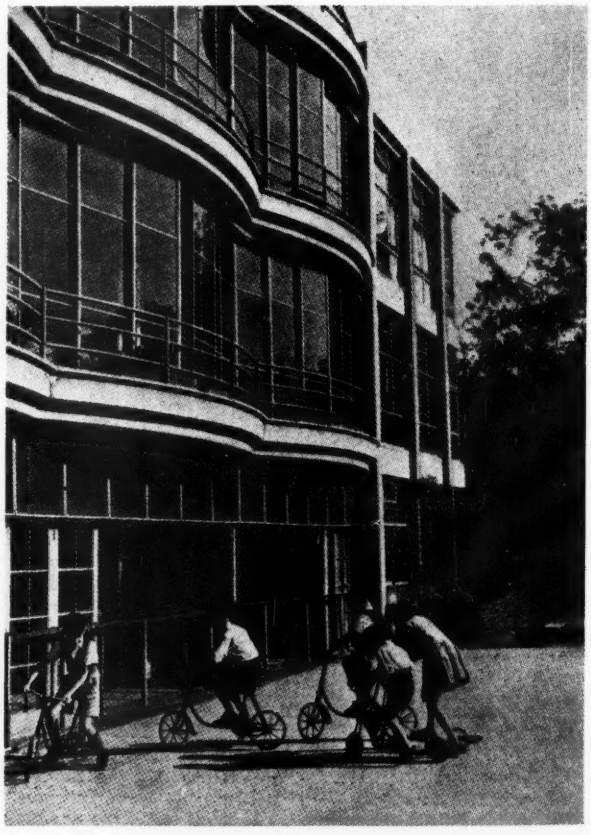
Six hundred members of the Pioneer Health Centre in Peckham petitioned every member of Parliament that their building might be released from its wartime use and once again be made available to them. After some delay the manufacturing firm quitted the premises, which had to be cleaned and overhauled before they could revert to their original use. Although the neighbourhood in which it stands has been seriously damaged by enemy action and a large part of the building consists of glass, it is remarkable that it has escaped with comparatively little damage, although somewhat the worse for wear.

By a happy chance the formal reopening coincided with the publication of the Government's Bill for the establishment of a national health service. It contains a provision imposing upon every local health authority the duty to provide, equip and maintain to the satisfaction of the Minister premises which shall be called "health centres". The promoters of the Peckham Centre contend that this is debasing their name by applying it to a center which will be more in the nature of a polyclinic.

It was a beautifully fine afternoon and the bright sun demonstrated to the full the advantages of the construction of the building with large panes of glass, while stimulating, the general rejoicing at the restoration of activities of so much value to the life of the people. Visitors from all parts of London joined with the members in constituting an audience of well over a thousand people.

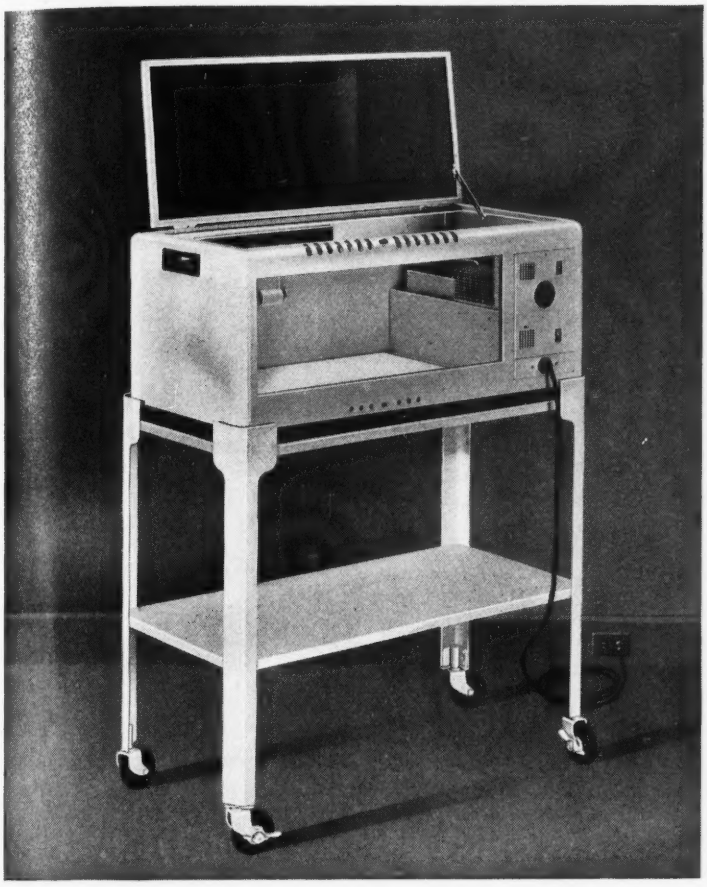
Lord Geddes, formerly Principal of McGill University, paid a compliment to the intelligence of his audience by giving them a reasoned address worthy of the opening of an academic session. He explained the biological foundations of health, which he traced back to a period before the conception of the child. Health, he defined to be a state of wholeness of body, soul and spirit. In order that it may be secured for the child there must be affinity between the parents in each of those spheres. The speaker's reasoning lent little support to the theory that one mate might be complementary to the other or that a happy union might be formed by contrasts. In particular experience had shown that the saintly father impressed by a belief in his own good works was only doing the work of the devil and invariably creating conditions productive of abnormal children. Again perhaps the learned lecturer rather overstated his case in order to impress his point, as the high proportion of men in the *Dictionary of National Biography* whose homes were in country parsonages is a solid piece of evidence which cannot be dismissed lightly.

(Concluded on page 78)



A View of the Peckham Centre.
(Photograph from "The Hospital")

ARMSTRONG X-4 PORTABLE BABY INCUBATOR



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- 15. Night light over control
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- 17. Safe locking ventilator
- 18. Low operating cost
- 19. Automatic control
- 20. No special service parts
- 21. Safety locked top lid

IN offering you the Armstrong X-4 Portable Baby Incubator we stand firmly on the principle that we must provide a SAFE Baby Incubator, a LOW COST Baby Incubator and a SIMPLE Baby Incubator. That we have succeeded is evidenced by the fact that in less than a year, close to a hundred voluntary repeat orders have been received. It is now in use in 46 States as well as in Canada and Latin America. More and more it is being used, not only for the premature baby, but for any debilitated or under weight term baby. We sincerely believe you will like it.

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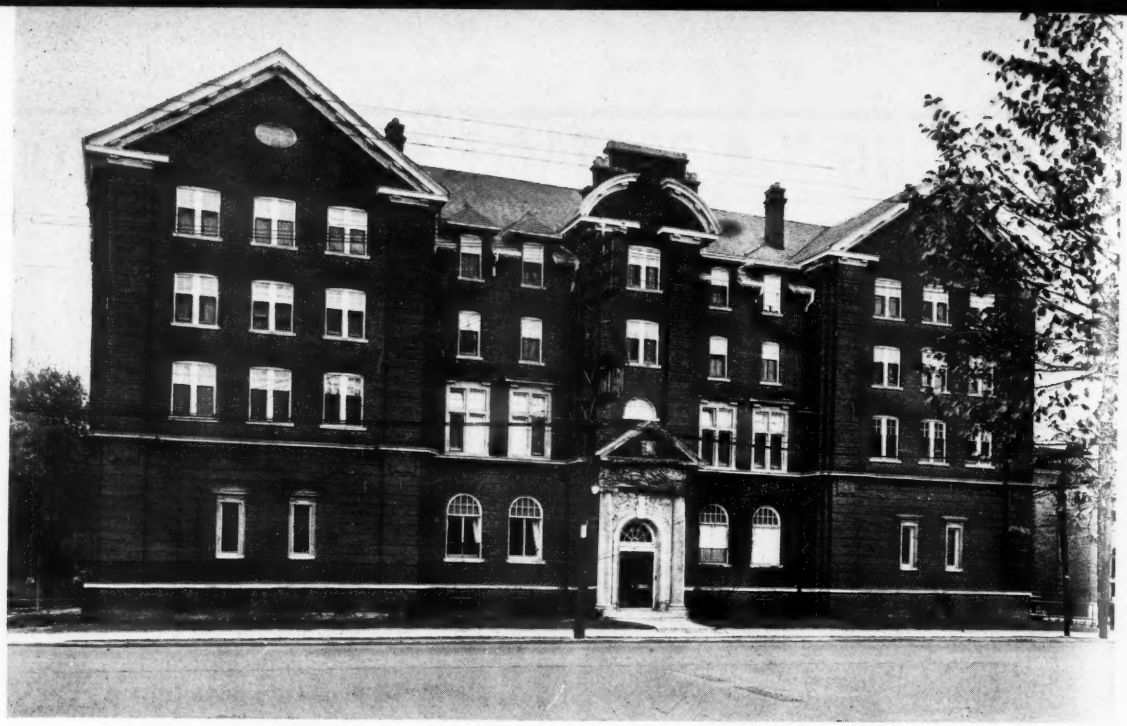


The New Headquarters

Plan for Hospital Care (Ontario) Buys Home for Fifth Anniversary

FIVE years after enrolling its first participants, the Plan for Hospital Care (Blue Cross) in Ontario is about to move into its new home. This fine building at 135 St. Clair Avenue West (corner of Avenue Road) in Toronto will become the new headquarters for the Plan, now housing its 210 employees in some fourteen locations in downtown Toronto. The house was built and used as a training school for deaconesses by the United Church of Canada and then during the war it became a residence for enlisted women.

This building, with a floor area of some 50,000 square feet has unrestricted light on all four sides as it extends on St. Clair Avenue from Avenue Road to Foxbar Road and has a large parking space at the rear. It is in the form of a hollow square with a central light court, ensuring good ventilation and inner lighting.

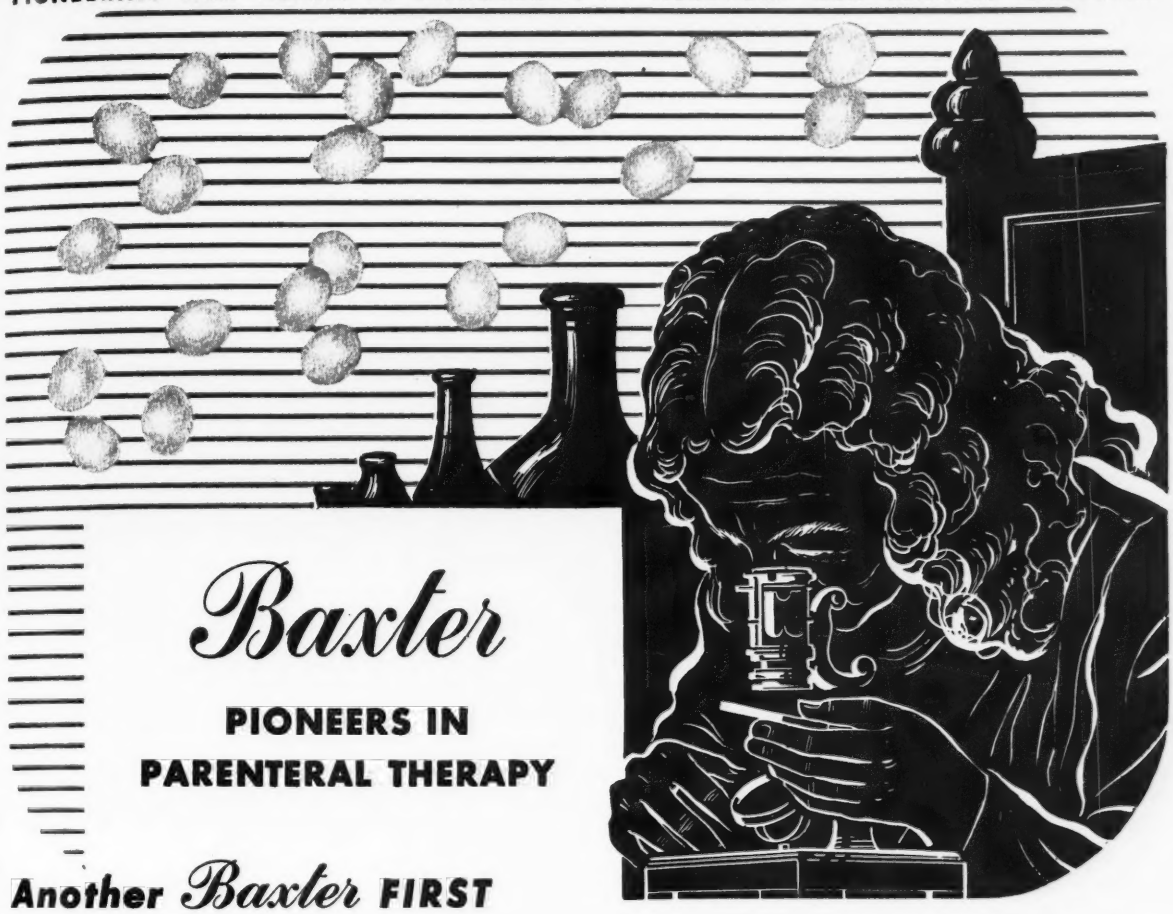
Unfortunately, immediately after its purchase, the City found it necessary to take some two-thirds of the building for housing purposes and so for the next three years or so only a part of the Plan for Hospital Care can be accommodated in the new quarters. Much of the staff will be required to remain in other locations for the time being.

Ultimately, when the whole building can be used for the purpose for which it was purchased, it is hoped to make it a headquarters for both hospital and medical organizations. With that thought in mind, part of the presently available space is being turned over to the Canadian Medical Association, the Ontario Medical Association and the Royal Canadian Institute, three associations which, along with the Canadian Hospital Council, have had to give up their quarters on the University campus to permit the erection of the new chemistry building on College Street.

Since the inauguration of the Plan for Hospital Care in March 1941, this Blue Cross Plan has grown to over 600,000 participants, despite the discontinuance of many war industries. Up to March 31, 1946, hospitals have been paid $4,638,297.71. Naturally these figures have increased each year with the growth in membership and nearly half of this amount was spent in the preceeding 12 months, namely, $2,071,244.40. At the present time the income from subscriptions is at the rate of well over three million dollars a year. This is big business. Adequate reserves are being maintained for emergencies and possible epidemic conditions as required by the Department of Health.

The success of this non-profit plan, owned and operated by the non-profit hospitals of the province through their provincial organization, is ample evidence of the public need for this type of plan. The fact that credit unions and other organizations are now copying Blue Cross benefits and contract forms, sometimes word for word, is further evidence of the intrinsic soundness and appeal of this type of service plan.

PIONEERING THAT POINTS TO *DISCOVERY* . . . *DISCOVERY* THAT *DEMANDS* LEADERSHIP



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1632-1723

This great microscopist in 1674 gave the first description of the red blood cells and demonstrated the capillary anastomosis between the arteries and veins, previously discovered by Malpighi in 1661. His extensive studies on capillary circulation completed Harvey's demonstration of the circulation, preparing the way for today's parenteral therapy.

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Osteopaths Score

While Physicians Squabble

U.S. osteopaths, in their invasion of medical practice, have overrun much of the physician's territory during the last four years. And the invasion has proceeded with little successful resistance from organized medicine.

Best clinical example is the State of Maine. An analysis of the gains osteopaths have made there, and an answer to the query, "How do they do it?" have intimate implications for American practitioners everywhere.

Maine has a Board of Osteopathic Examiners whose chairman declares that his state has more osteopaths per capita than any other state in the union. The osteopaths swarmed into Maine not because of its salubrious sea and mountain air but because of its healthy legal climate. Maine laws give osteopaths the right "to use such drugs as are necessary in the practice of surgery and obstetrics, including narcotics and anaesthetics". On birth certificates, commitment papers and other documents, an osteopath's signature has the same validity as one followed by the letters "M.D.". Osteopaths are authorized to use the prefix "Dr." and *state-aided hospitals are required to permit them to send in and treat their own patients in their own manner.*

The war has favoured their cause in several ways: since most osteopaths were ineligible for medical commissions, there was not the same Procurement and Assignment Service pressure on them as on M.D.'s. About a fifth of Maine's physicians answered the call to the colours; and their patients, finding regular practitioners already overburdened, often turned to the osteopath because no one else was available. Finally, most doctors of medicine, being busy and prosperous, were disciplined to carry on any intensive fight against non-medical practitioners. Thus osteopaths, not only in Maine, but all over, were beneficiaries of the ill wind of war.

Osteopaths are harmoniously organized and make full use of every technique in the lobbyist's bag of tricks. Their societies are well staffed with lawyers, legislative representatives and public relations experts who know the ropes. Where the M. D. takes the attitude, "This technical health question must be left to the doctors; you laymen cannot understand", the osteopaths bring the public right into the hearing room with them.

They do not waste energy and whip up hostilities by empty and violent charges of "communism" and "regimentation" and "fascism". They simply tell legislators: "We are a group of healers trying to help the public; here is a batch of satisfied patients. Let them tell you how they would have been robbed of their health if you had had this restrictive law". One of their effective methods has been this technique of sending to the state capitol a swarm of enthusiastic patients as living testimonials to clamour for or against proposed legislation. To the lawmakers, this looks—and sounds—like the beating pulse of democracy, a veritable people's lobby.

The medical profession and the hospitals in Canada might well take note of this situation. It could happen here.

Physicians are shocked at such tactics and feel that Hippocrates would turn over in his grave if they ever brought patients into a legislative hearing room. Yet the osteopaths' methods pays off when the roll-call sounds . . . .

Having attained a healthful legislative climate, the osteopaths' next step is to *promote* their cult. They use billboards, booklets, newspaper publicity and radio. At least seven osteopathic radio programmes are now on the air waves. The A.O.A.'s monthly "Osteopathic Magazine" and other periodicals for the laity feature the names and pictures of prominent patients, give plausible and interesting explanations of the effectiveness of osteopathy and include convincing editorials. Vigorous campaigns are waged to place material in the public press too.

Compared with this kind of human-interest copy, the regular medical society's releases on "Take your Baby to the Doctor Every Six Months" or "Health Insurance is the Wedge to Collectivism" seem pretty insipid. But since giving publicity to cures and names of prominent patients is forbidden by medical ethics, the osteopaths have a clear, competitive advantage.

Osteopaths also exploit their very defects. If an unnecessary operation is performed on a physically healthy person, it is almost certain that the patient will recover. And if the osteopath has told him that his condition was serious, the patient will certainly conclude that the operation saved his life. Result: one more enthusiastic convert.

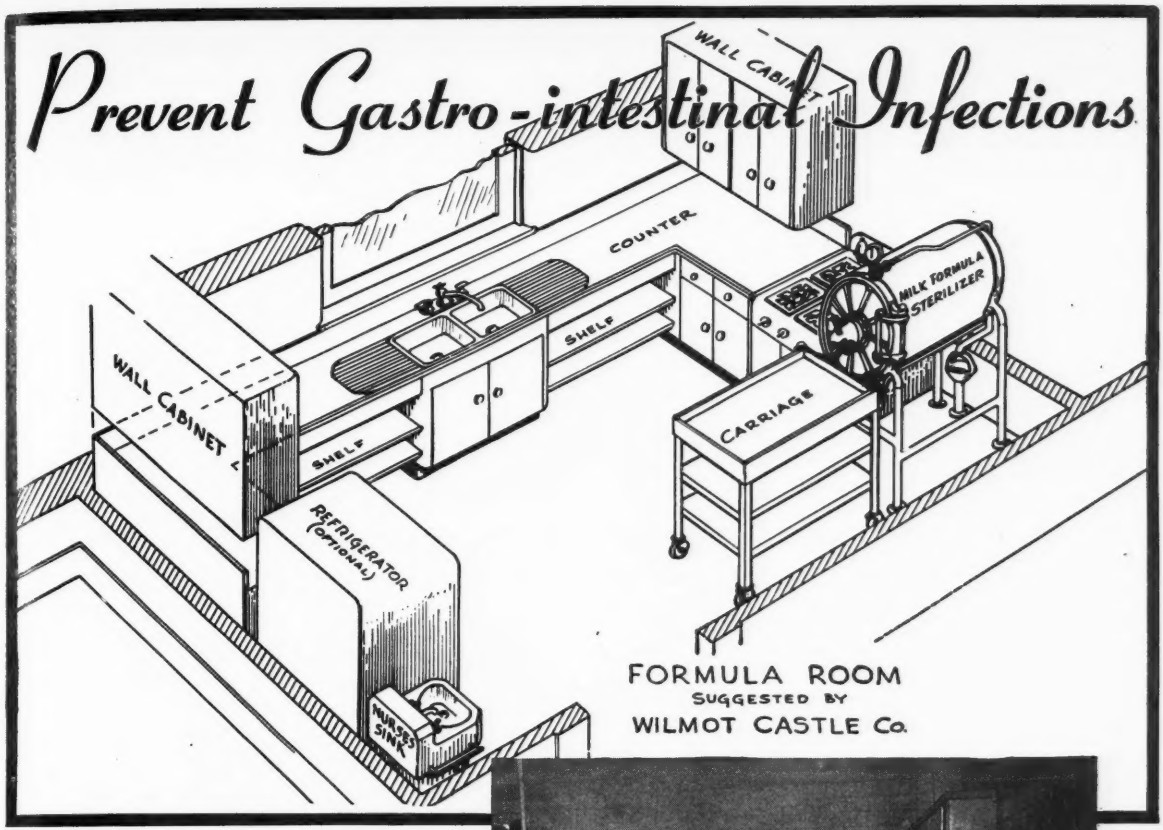
The present osteopathic beachhead on medical territory has some particularly disturbing implications for the future. So far, the most serious inroads have been made in rural areas. If M.D.'s continue to flock to cities and towns, they abandon the farms and villages to the cultists by default. It is, however, more serious than that. For if osteopaths flourish increasingly in rural areas, they will certainly extend their activities. What happens at the grass roots has considerable weight in legislative centres. For instance:

The recently-enacted H. R. 4717 (setting up a Medical Department in the Veterans Administration) puts osteopaths *on a par with M.D.'s.* This bill, passed without a single dissenting vote, says that a candidate for appointment in the V. A. medical service "must hold the degree of doctor of medicine or of doctor of osteopathy . . . and be licensed to practise medicine, surgery or osteopathy in one of the States . . . ." What's more:

In the interpretation of the G. I. Bill of Rights, all accredited osteopathic colleges are on the approved list, so that veterans may attend such institutions with tuition and subsistence paid by Uncle Sam. This spells

(Concluded on page 84)

Prevent Gastro-intestinal Infections



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Anaesthetic Explosion Hazards

EXPLOSIONS of anaesthetics used in the operating room have become a matter of much concern during the last five years. The incidence of such explosions is not great—perhaps one in 300,000 administrations — but the fact remains that it is a preventable hazard and is so dramatic that when one occurs it is headline news with attendant injury to the reputation of the hospital and, worst of all, may act as a deterrent to the entrance of patients in need of surgery.

All inhalation anaesthetics, with a single exception, are volatile hydrocarbons and therefore explosive when mixed with the proper proportions of air. The single exception is nitrous oxide (laughing gas) which is actually an asphyxiant rather than an anaesthetic and even this gas gives up its oxygen so easily as to be a good supporter of combustion. As these anaesthetic gases escape from the patient or from the apparatus there is virtually always some zone close to the point of escape in which the mixture of anaesthetic and air is in the right proportion to explode if a suitable source of ignition comes in contact with it.

Of the possible sources of ignition, free flames, cigars, cigarettes, etc. are easily excluded from the operating room but electric sparks either from the regular circuits or from static electricity require special means for prevention. Sparks from electric circuits can be prevented only by the use of electrical equipment, appliances, etc., certified by the Underwriters Laboratories, Inc. and by regular inspection to detect faulty connections or other possible sources of short circuit. Static electricity is much more elusive, all pervading, difficult to control and, in the opinion of the best qualified observers, is responsible for ignition in at least 80% of all anaesthetic explosions.

Static electricity is generated whereever there is friction but if in contact with a good electric conduction path to the ground will filter away to ground about as fast as it is generated and not accumulate in a sufficient amount to cause a spark. But if any non-conductor is interposed in the path to ground, even the smallest trickle can accumulate to a pool of dangerous potential.

Thus the prevention of static ignition becomes a matter of providing a conductive path for the removal of static, as it is not practicable to prevent its generation. This conductive path must extend without interruption from the patient to some point of electrical contact with the ground such as a water or plumbing pipe or some comparable metallic conductor.

During construction the principal item to be considered in this connection is the floor material or its surfacing treatment. The tile or different types of cement floors formerly in common use are not conductive. Neither is linoleum or the ordinary rubber flooring material.

When the problem was first recognized the first attempt at its solution was to lay a large steel plate on the floor and connect it to a convenient water pipe. A somewhat later method was the use of terrazzo laid in rectangles separated by brass strips interconnected and connected to a ground. This had the fault that the conduction was effective only when the equipment, personnel, etc. were in contact with the brass strips but not when the sole contact was with the terrazzo itself. And the larger the grids the greater the space between the conductive strips and the lesser the chance of contact with them. Next followed an era of drag chains on the theory that some part of the drag chain would always be in contact with one of the metal grid strips in the floor.

Then came the development of a rubber composition containing sufficient conductive material to render the entire floor area conductive. This material was entirely effective and production, halted by the war, will probably bring it back into the market as soon as other needed materials are again available. One objection to this material is its color —black—which is undesirable in in operating rooms.

Another product developed for this purpose was a concrete containing sufficient metallic salts to render it conductive. This material has had some success as a conductive floor in munitions plants but it has not yet had enough of a trial in hospitals to justify any conclusions as to its suitability.

(Concluded on page 82)

—From "The Administrative Aspects of Hospital Construction", by W. P. Morrill, M.D., Director of Research, American Hospital Association. Published in "Hospital Review," 1945.

Dr. J. D. Heaslip

Superintendent of the Calgary General Hospital

Dr. J. D. Heaslip, the new superintendent of the Calgary General, graduated from the University of Manitoba in 1916 and served in the R.C.A.M.C. during the war period. Following several years of practice in the Edmonton area, Dr. Heaslip took post-graduate work overseas in surgery at London, Edinburgh and on the continent. On his return to Canada he joined the Ontario Department of Health, where he was a director of Medical Services and did surgery in the mental hospitals. Since 1936 he has been superintendent of the Ontario Reformatory at Guelph, a post which he left to assume his new duties at Calgary.

(Photograph by Extension Department, Ontario Agricultural College)

Stafford's tomato soup BASE

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Crême of Tomato Soup

. . . and *so easy* to prepare, too . . . just add milk. Here's real economy—one pound of Stafford's Tomato Soup Base makes two imperial gallons of delicious Creme of Tomato soup.

Chefs use it as a stretcher in their own tomato soup because it tastes like real *home-made* Creme of Tomato Soup.

Like all Stafford products, this Tomato Soup Base comes to you under the *Stafford Laboratory Controlled label* . . . your guarantee of purity and reliability that enables you to buy with *complete* confidence and satisfaction.

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Price Ceiling Lifted on Many Articles

On April 14th, the Wartime Prices and Trade Board announced a number of additional categories of goods and services from which maximum price regulations were suspended. Items of interest to hospitals are the following:

Thermometers; barometers.

Surgical and dental instruments, apparatus and accessories of all kinds, including (a) sterilizing equipment of all types; (b) physiotherapy equipment; (c) surgical needles; (d) clinical thermometers; (e) hypodermic syringes and needles of all types; (f) X-ray apparatus and accessories; (g) aneasthetizing equipment; (h) glassware and other scientific apparatus for laboratory work in hospitals or clinics; (i) surgical and dental furniture and equipment designed especially for use in hospitals or by physicians or dentists in offices or laboratories; (j) hospital and surgical utensils or stainless steel or enamelled steel, including pus basins, urinals, bed pans, catheter trays and instrument trays, but not including kitchenware;

Articles produced from glass tubing but not including containers for products for resale.

Cements as follows; stove, roofing, linoleum.

Fertilizers and pesticides as follows; humus, muck, manure, sphagnum moss, peat moss.

Office supplies as follows: (1) arch and clipboard files and arches for same; (2) cups and trays for clips, sponges or pins; (3) typewriter and pencil carbon paper but not including continuous form or fanfold; (4) copy holders and list finders; (5) paper clips, including florists' type; (6) paper fasteners; (7) moisteners; (8) stenographers' note-book holders; (9) desk pads; (10) ink pads; (11) hand paper cutters; (12) desk-size paper punches; (13) paper weights; (14) inked typewriter and business machine ribbons; (15) hand type envelope sealers; (16) manual pencil sharpeners; (17) erasing shields; (18) staple removers; (19) hand type rubber or steel stamps; (20) telephone indices; (21) thumb tacks; (22) drawing and drafting boards; (23) draughting instruments.

Furniture as follows: (a) wooden or upholstered furniture when sold at retail and built to the specifications of the buyer; (b) wooden medicine cabinets.

Chemicals as follows: (a) essential oils and aromatics chemicals, natural or synthetic, including menthol and camphor; (b) cascara bark.

Only two new items have been included in the list of services suspended from maximum price regulations. These are the repairing, maintenance and installation of electrical wiring and equipment, and welding.

Additional foods suspended from ceilings include fresh or frozen crabmeat, clam meat, oysters, shrimps, sturgeon, roe, skate wings, sword fish and tuna fish; canned abalone and canned shad and eels.

Other miscellaneous items added to the list of suspensions include all wax polishes and shoe polishes, razors of all kinds; lighter fluids, household articles of cast aluminum ware, trays of all kinds; electric incandescent light bulbs and fluorescent tubes.

Copies of the order, with the full list of suspensions and various examples to illustrate the terms of the regulations, may be obtained at any office of the Wartime Prices and Trade Board.

Miss Jean Taylor Appointed

Miss Jean Taylor has been appointed Superintendent of the Daughters of the Empire Hospital for Convalescent Children in Toronto. The former Superintendent, Miss L. Loraine Morrison, resigned in December because of ill health, after some fifteen years of service. Warm tribute was paid to her administration by the President, Mrs. A. E. Gooderham, at the annual meeting.

Miss Taylor was in the Services for five and one half years, serving in Canada and Overseas, and in the first group of nursing sisters decorated with the Royal Red Cross by His Majesty in 1941. Miss Taylor will take over in June. In the interval Miss Flora Phillips has been acting superintendent.

Hospitals and Group Practice

A further projection of the hospital's function in the future is development of the group practice of medicine. If we are to visualize the hospital as providing comprehensive medical service, it is clear that the institution must be the focus not only of modern equipment and facilities, but also of shared medical knowledge, experience, and skill. As medical science becomes more complex, the physician is obliged to use more technical aids and more consultative advice. Thus if the benefits of modern medicine are to reach all of the people, we must make it possible for doctors to work together in groups, pooling their abilities, the special knowledge of one supplementing the knowledge of the others. The hospitals are the logical centres for such service.

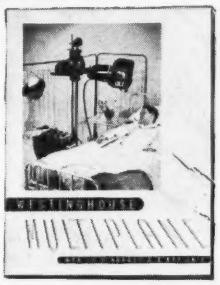
In fact, it is through the hospitals that the concept of group practice has grown. Our great university hospitals and many private centres such as the Mayo, the Lahey, and the Crile Clinics represent the development of group medicine to the peak of performance and prestige. On a smaller scale, we have many examples of group practice developed by the physicians of a community in co-operation with their local voluntary hospital.

As we plan for expanded hospital and health services in all parts of the country, which would provide complete medical and health care for all of the people, we should assume that group medicine will be practised on a much wider scale than ever before. The voluntary hospital, looking ahead, can begin now to anticipate this trend. Progressive institutions and the physicians associated with them are united in their belief that to improve medical care and to make it more widely available demands such planning and organization for the future.

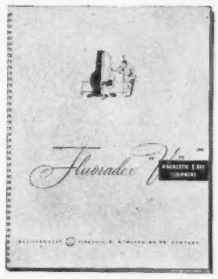
—Thomas Parran, M.D., Surgeon General, U.S.P.H.S.

THE MULTIPLANE MOBILE

A high-capacity, complete x-ray unit for any examination which can be made at the patient's bedside. Where adequate elevator facilities are not readily available—or for examinations at the patient's home—the Multiplane portable units may be dismantled easily into small components for such work. They provide every feature of the mobile unit (Bulletin 356).

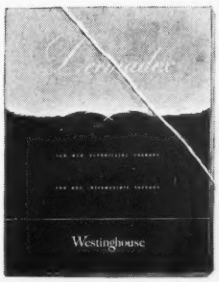


FLUORADEX V



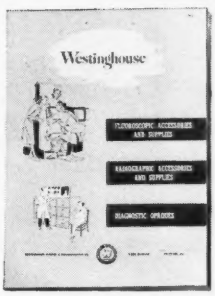
Unchallenged leader of x-ray equipment for general duty. Compact and efficient, it utilizes all the features found in larger equipment and is available to smaller institutions for general use, or to serve as supplementary equipment in busy departments (B-3337-1A).

DERMADEX



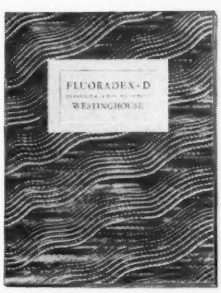
Available in two-voltage classes for skin clinics, dermatologists and x-ray departments requiring x-ray equipment for treatment of skin lesions (Bulletin 362).

SUPPLIES AND ACCESSORIES



There is a complete line of Westinghouse supplies and accessories available for every type of x-ray. Full descriptions are contained in this compilation of this material (B-3391-A).

FLUORADEX D



The finest in radiographic equipment, Fluoradex D introduced to radiologists many innovations in operative techniques. The product of continuous pioneering, Fluoradex D is today the most versatile and accurately manipulable x-ray apparatus available (Bulletin 830).

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Especially designed for deep therapy. Because of generator size and design, the radiation output of the Quadrocondex is considerably greater than that of the Duocondex. Choice between the two is determined by the size of the institution, the amount of work to be done, and the speed at which it must be handled (Bulletins 464 and 469).

here's help on every x-ray need

First in a long list of x-ray developments, Westinghouse builds equipment and supplies for every x-ray application. On this page are capsule descriptions of important Westinghouse contributions in x-ray equipment. You can secure full details in the booklets whose numbers are listed in parentheses in each paragraph.

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Electronics at Work

Here and There

By the Editor

Six Pawns for a Queen

Dr. Edward H. Hume of New York, secretary of the Christian Medical Council for Overseas Work, and founder and former president of Yale-in-China University, tells of an incident that happened to his grandparents many years ago, when they were on their way from Salem to Bombay back in 1839. When the little brig put in at Zanzibar for supplies, the Sultan invited a number of the passengers to visit the palace.

In the course of conversation the sultan revealed that he was much puzzled over a present recently sent to him by Queen Victoria. What could it be? To their amusement the guests found a huge grand piano in a corner of the reception room, lying upside down with its legs in the air. As these legs seemed to be the most beautiful part of the contraption the sultan had turned that side up. It was explained that the object was a grand piano and that it should be put in its proper position. This was promptly done by the servants. Thereupon the young Mrs. Hume, who was an accomplished musician, sat down at the piano and began to play for His Majesty.

The sultan was delighted with this wonderful toy and insisted that she go on playing piece after piece. Suddenly he had a brilliant idea. An aide was hurriedly dispatched from the room and, about five tunes later, ushered in six beautiful ebony maidens, resplendent in their beads, if little else. Turning to Mr. Hume the sultan proposed a dicker: "I'll swap these six beautiful wives for that wife of yours, so she can stay and play the piano for me." Had that swap been made, the present Dr. Hume might have had a somewhat darker complexion than he has.

These and many other stories relating to Dr. Hume's experiences in China are to appear in a few weeks in a new book entitled, "Doctors East, Doctors West", the current winner of the $3,500 Norton Medical Award.

* * *

Support for Margarine in Senate

Senator C. J. Veniot of Bathurst, prominent New Brunswick physician, is to be congratulated on his strong support of Senator Euler's proposal that the use of oleomargarine for food purposes be permitted. Senator Veniot, in joining his voice with that of others in support of the measure, pointed out how essential it is that diabetics be given an adequate fat content in their diets.

The much-paraded statement that oleomargarine has inadequate food value has long since been exploded. Actually its caloric value is identical with that of butter. The animal fat margarine does lack the vitamin A content of butter, but so do a great many other foods that we eat. Vitamin figures for the modern soybean type of margarine are not at hand. The real reason for the opposition would seem to be the fear of the dairy interests and milk producers that the public will get weaned away from the use of milk-fat, thus affecting their personal returns. With the obvious inability of Canada to supply enough butter for its own needs and our export obligations, this factor should not weigh too heavily. Actually when salted and coloured (as is the practice with butter), margarine is a highly desirable, nutritious and low-cost article of diet.

* * *

Income Tax Unfair

The return of the annual deadline for the payment of income tax reminds us again of how the regulations discriminate against many medical men on salary. Salaries are still considered as "net", despite the fact that many men on salary have expenses pertinent to their work. This applies to pathologists, radiologists, full time clinicians, medical administrators, research workers, etc.

Doctors in practice are entitled to deduct association membership dues up to $100.00 per annum, but the man on salary, with as many and frequently more professional dues to pay, cannot deduct them.

Even the fee for the licence to practice, essential to radiologists, clinicians, full time school or industrial doctors and others on salary cannot be deducted.

Automobile expenses, including depreciation, cannot be deducted by doctors on salary despite their frequent need for a car. (Sometimes essential expenses can be arranged by the provision of a special allowance for that purpose).

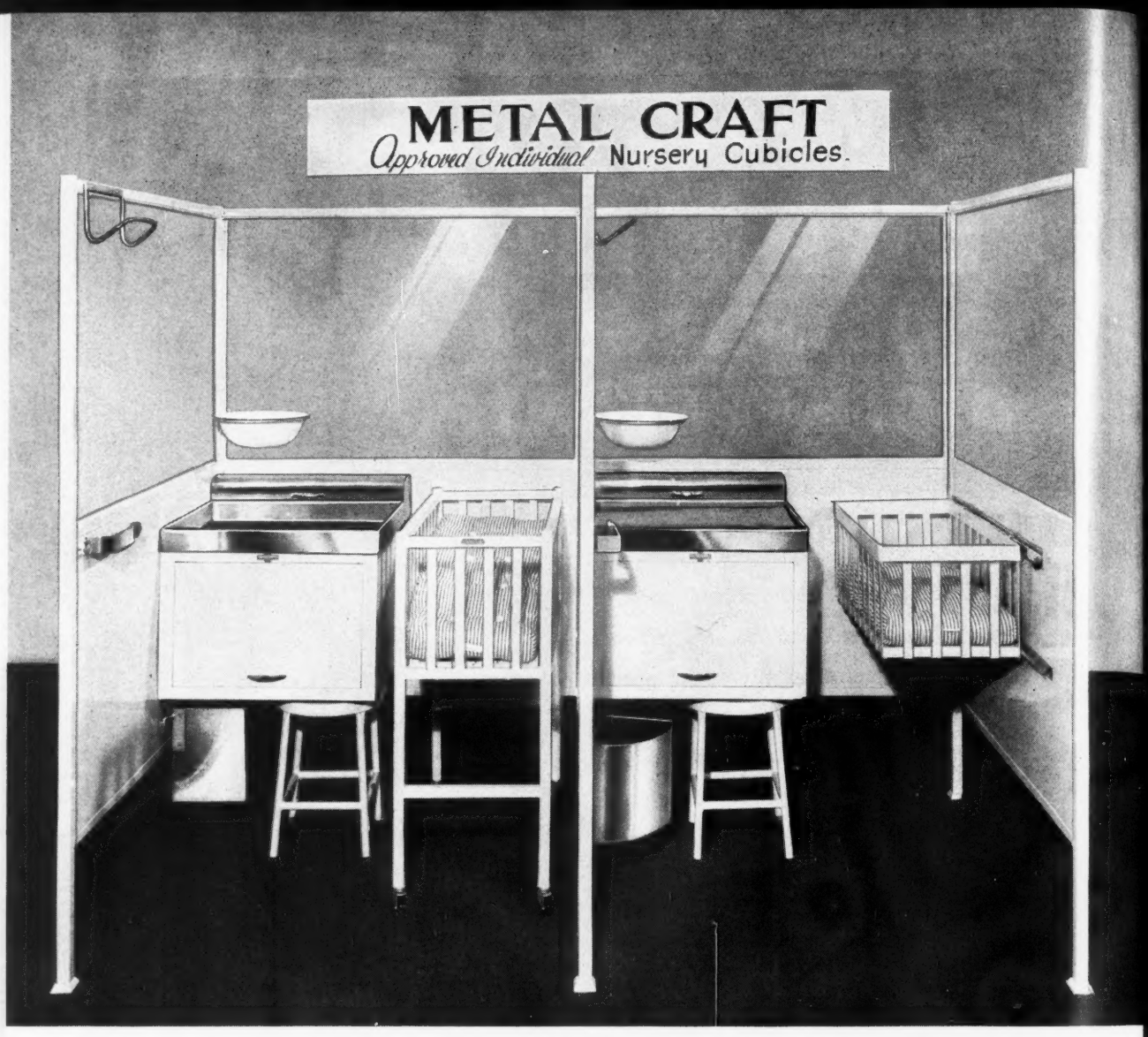
The doctor in practice may deduct the cost of all new medical books in his library. The man on salary also must keep up to date in his field and must buy many, and frequently all, of his books himself. But he gets no deduction.

These anomalies should be corrected, particularly as the physicians on salary average a much lower income than their colleagues in practice.

* * *

Canadian Medical Services Journal in New Dress

Congratulations are in order to the Editor and Board of the *Journal of the Canadian Medical Services* which, in its March issue, came out in a very attractive new cover and set-up. This Journal has been issued by authority of the Ministers of National Defence, Defence for Air, Veterans Affairs and National Health and Welfare, and the Editor is Lieut.-Col. W. R. Feasby, R.C.A.M.C., now assistant superintendent of the Toronto Western Hospital, with Brigadier G. R. D. Farmer, R.C.A.M.C. of Hamilton as Chairman of the Editorial Committee.



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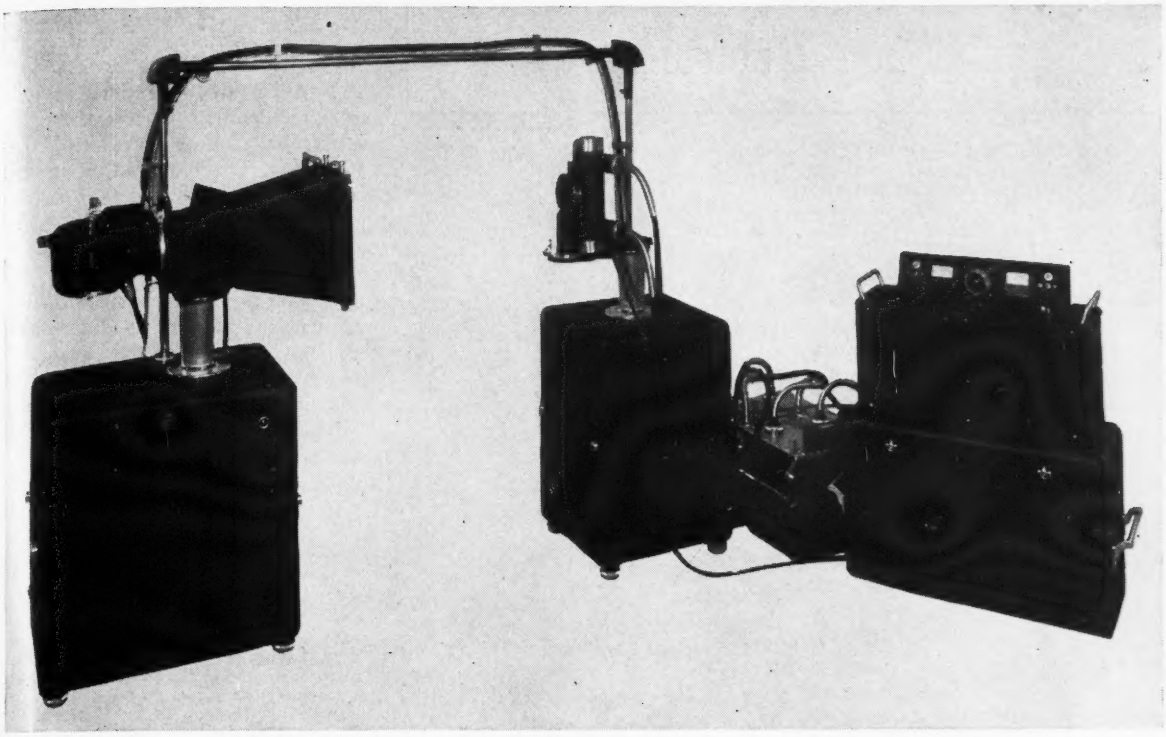

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Book Reviews

THE MODERN SMALL HOSPITAL and Community Health Centre. 138 pages, 10 by 14 inches, illustrated. Published by the Modern Hospital Publishing Company, Inc., Chicago, 1946. Price, $7.50.

This beautifully illustrated volume is based upon the architectural competition held by *Modern Hospital* some months ago for designs for 40-bed hospitals and community health centres. At that time there were some seventy-seven entries. All of the prize-winning plans and those which received honourable mention are included in this volume as well as twenty-nine other plans, some forty-one in all.

These plans, with elevations or perspective drawings and site layouts, will be of tremendous value to the many committees now considering the erection or replacement of small hospitals throughout the continent. The plans included have their value enhanced by virtue of the helpful "contestant's statement" coupled with an "editor's statement" by way of explanation. On the whole the plans are of the low, spread-out type of building for a generous lot but there are a number with the two-storey type of building. Almost all of the designs are of distinctly modern style and reveal much ingenuity in the arrangement of services and space for present day facilities, including quarters for the community health centre. This added feature makes the collection of special value.

While some of the plans are designed primarily for warmer sections of the continent, most of them can be adapted for Canadian use. However, rightly or wrongly, Canadian architects have not gone into the low type of building to any extent. This may have been largely because of the desirability of minimizing heat loss and the problems created by snow as a result of extensive roof area, the desirability of having a basement and the added cost of excavation. Our tendency here has been to reduce to the minimum outside surfaces as compared with the cubic contents. It may be that we have inclined too strongly in this direction in view of the possibility of health insurance.

In addition to the many line and wash drawings, there are some very helpful chapters by Dr. Otho F. Ball, publisher; Mr. Alden B. Mills, editor; and Dr. Thomas Parran, director general of the United States Public Health Service. There is an article on "The Need", by Joseph W. Mountin, M.D., of the U.S.P.H.S.; "Community Survey", by Fred G. Carter, M.D., of Cleveland; "The Consultant", by Everett W. Jones, vice-president of The Modern Hospital Publishing Company; "Architecture and Design", by Mr. Marshall Shaffer, chief hospital architect, hospital facilities section, U.S.P.H.S.; "Organization and Finance", by Graham L. Davis, hospital director, W. K. Kellogg Foundation, Battle Creek, Michigan; "Professional Organization", by W. S. Rankin, M.D., director, hospital and orphans section, The Duke Endowment, Charlotte, N.C.; "Administrative Organization", by William J. Donnelly, administrator, Greenwich Hospital, Greenwich, Conn.; "Patients' Needs", by Carl A. Erikson, architect, Chicago; and "Materials", by Addison Erdman, architect, New York; Mr. A. A. Aita, superintendent, San Antonio Community Hospital, Upland, California, has prepared a check list of equipment. The format is an excellent example of the bookmaker's art and reflects much credit on those who designed it.

Although some of the plans may not be as applicable to the Canadian scene as are others, the work is an outstanding one and can be heartily recommended to hospital architects and to building committees.

* * *

MEDICINE IN INDUSTRY. By Bernhard J. Stern, Phd., Lecturer in Sociology, Columbia University, Visiting Professor of Sociology, Yale. Pp. 209. Price, $1.50. U.S. Commonwealth Fund, 41 East 57th Street, New York 22, N.Y., 1946.

This book is the fourth in a series issued under the auspices of the Committee on Medicine and the Changing Order of the New York Acedemy of Medicine. Dr. Stern traces the social, economic, legal and professional setting within which industrial medicine has progressed and the development of the scientific knowledge which has enabled industrial physicians to cope with disease affected by occupations. He presents data on the rates of industrial disability and points out the limited extent of preventive services. He also considers insurance problems, the problems of the handicapped in industry and the relationship between the industrial physician and the general practitioner. Dr. Stern concludes from his findings that despite much progress in this field, the mass of the workers still have inadequate medical care and that industrial medicine offers an approach to preventive medicine and public health which should be intensively developed. He makes suggestions for future advances in a clear and objective style.

* * *

JOURNAL OF THE HISTORY OF MEDICINE AND ALLIED SCIENCES. Volume 1, Number 1. Pp. 182, illustrated. Subscription rate in the United States, Canada and Latin America, $7.50 (U.S.); elsewhere $8.50. Single copies, $2.50. Published quarterly by Henry Schuman, New York 21, N.Y. George Rosen, Editor.

Published under the direction of a distinguished Board of Editors and Consulting Editors, this new quarterly, judging by the initial issue, would seem to be a very promising one indeed. Although there are several interesting publications on medical history, including the fine *Historical Bulletin* of the Calgary Associate Clinic, the only other one of the pretentions of this new journal is the *Bulletin of the History of Medicine,* edited by Dr. Henry E. Sigerist. Editor George Rosen points out that the new quarterly is not to compete with, but will supplement the *Bulletin.* That is a fine distinction. The consulting editors representing Canada are Dr. William W. Francis of Montreal and Dr. T. G. H. Drake of Toronto, both medical historians of repute.

Among the contributed articles are ones on "Some Galenic and Animal Sources of Vesalius", "A Note on William Blake and John Hunter"; "Pharmacopoeias as Witnesses of World History"; "Medical Education in 17th Century England"; "Doctor Benjamin Harrison"; and "Animal Substances in Materia Medica". We can learn much from a study of medical history; to those interested in this fascinating subject, this new quarterly should prove most helpful.

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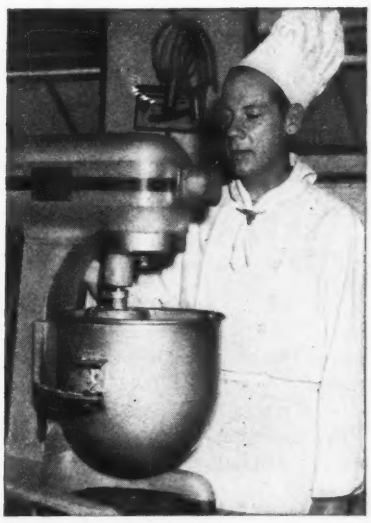

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Provincial Notes

(Concluded on page 74)

Nova Scotia

DIGBY — A gift of $1,000 has been presented to Digby General Hospital through Captain J. C. I. Edwards, commanding officer of H.M.C.S. Cornwallis. The money was voted from the Canteen Fund of the Ship's Company and has been given as a token of appreciation of the splendid care given to the wives and families of service men by the hospital during the war years. Before the naval base hospital was erected, H.M.C.S. Cornwallis was given full use of all the facilities of the Digby General Hospital and during that period six beds were kept at the disposal of the naval base.

LIVERPOOL — It has been announced that the Municipality of Queen's will support the new Queen's General Hospital at Liverpool, both by an outright donation to the building fund and by an annual grant for maintenance. This follows similar action on the part of Liverpool which earlier voted an annual grant of $500.00 plus free water, light and power for the proposed hospital.

Quebec

CAP - DE - LA - MADELEINE — The Hon. J. A. H. Paquette, Minister of Health for Quebec, has announced that the Government will make a grant of $150,000 to assist in the construction of a new 70-bed general hospital at this village. The estimated total cost of the proposed hospital is $325,000.

MONTREAL — The Minister of Health, Dr. Paquette, has announced that the Provincial Government will grant the Institute of Radium at Montreal $100,000 yearly for ten years to help in cancer research. He remarked that in addition to the Provincial grant the Institute also received a $50,000 annual grant from the City of Montreal.

NORANDA — The contract has been awarded for the construction of a four-storey, 100-bed addition to Youville Hospital. The architect is Auguste Martineau of Ottawa. The building will cost $500,000 and will include provision for heating, laundry service, space for the hospital staff and the Sisters. It will bring the total bed capacity for patients up to 200. Youville Hospital is run by the Grey Nuns of the Cross.

Ontario

BRAMPTON — The Peel Memorial Hospital at Brampton will be enlarged by the addition of a three-storey wing which will accommodate thirty patients. It will also provide a modern laboratory and x-ray room, and a new heating system is included in the plans. It is estimated that the cost will be in the vicinity of $200,000.

BRANTFORD — It has been announced that the Sisters of St. Joseph of Hamilton are acquiring Dufferin House in Brantford, former residence of the late Colonel Harry Cockshutt, one-time Lieutenant Governor of Ontario, for the purpose of transforming it into a hospital. The purchase price is $25,000. Architectural surveys are being made and remodeling will begin as early as possible. Due to the difficulty of obtaining supplies, the date for the opening of the hospital has not been set.

INGERSOLL — The Ingersoll Lions Club will shortly launch a campaign to raise funds for the erection of a new hospital in that town. The hospital will be a 30-bed unit costing approximately $150,000.

LONDON — Since the first of the year the D.V.A. has announced plans for the construction of three new buildings at Westminster Hospital, London. There will be a new infirmary, a new nurses' residence, and a "diversional occupational centre." This latter building will be part of a Health and Occupational Centre and will be used by convalescents from mental and physical illness after medical and surgical treatment has been completed.

LONDON — The W. K. Kellogg Foundation of Battle Creek, Michigan, is making a $30,000 gift to the University of Western Ontario to be used for staffing the School of Nursing. The campaign now in progress for funds for the building program of the University provides for $250,000 for a new school of nursing. None of the Kellogg grant will be used towards the buildings. Payment of the grant will be spread over a three-year period.

NEWTONBROOK — A campaign for funds to enlarge St. John's Convalescent Hospital will commence shortly. The hospital has been badly overcrowded for many months and it is planned to increase its capacity from 65 to 150 beds.

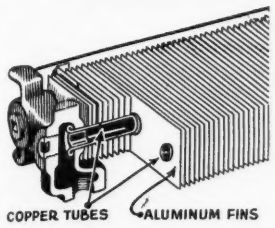
NORTH BAY — Dr. Main Thomson has been appointed specialist in charge of x-ray work at the North Bay Civic Hospital and has also been engaged in a similar capacity by St. Joseph's Hospital.

ORANGEVILLE — Plans are under way for the addition of a new wing to the Lord Dufferin Hospital in Orangeville. This will provide for twenty more beds, a new heating and laundry system, more complete x-ray equipment, etc. The present hospital of 26 beds has been overcrowded for some time.

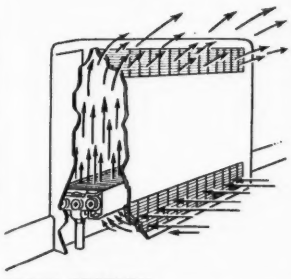
STURGEON FALLS — The new $300,000 hospital being built by the Congregation of the Sisters of Wisdom at Sturgeon Falls will be completed by this fall. It will be five storeys high and provide 60 beds and 16 bassinets, together with modern operating rooms, x-ray, laboratory and pharmacy.

TORONTO — The Physicians' Wives Association of the Toronto East General Hospital has presented through its treasurer, Mrs. R. A. Belfry, the sum of $2,500 to the Board of Governors of the hospital. This gift is a contribution to the building fund for the new wing soon to be added to the hospital.

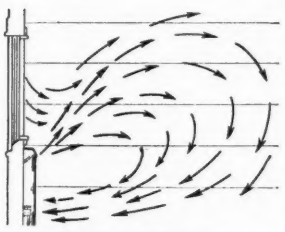
Here's the Inside Story!



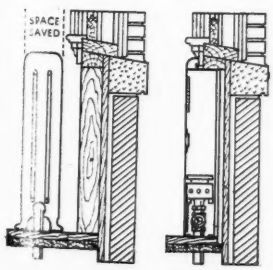
CUT AWAY SECTION of the Trane Convector-radiator heating element shows the construction and extended surface of the fins which are responsible for the added heating efficiency of Trane Convector-radiators.



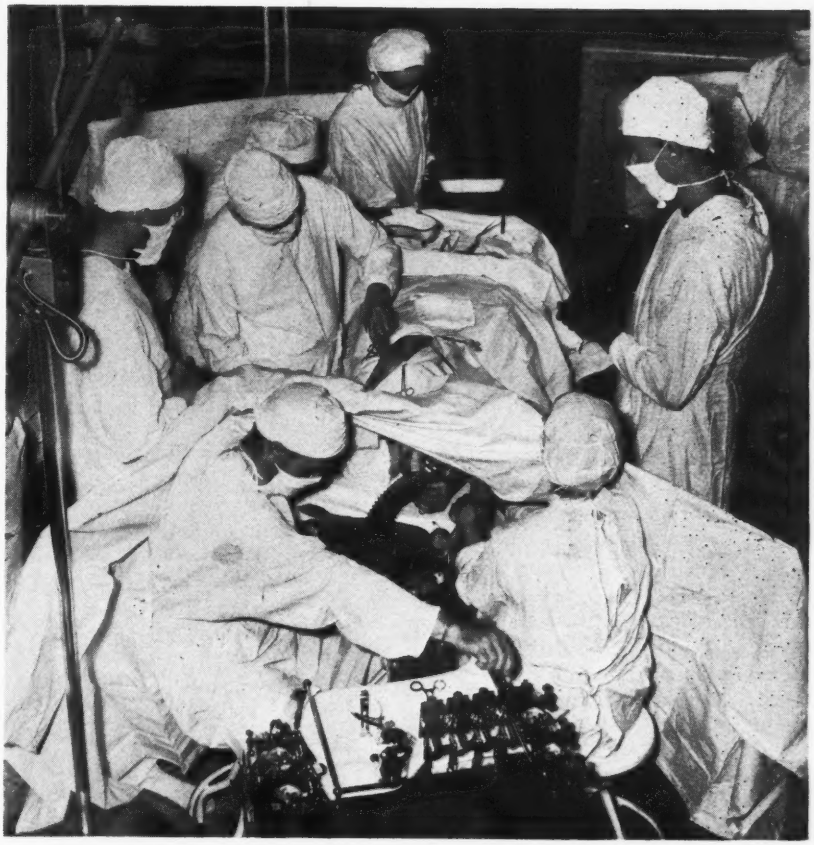
CROSS SECTION of Trane Convector-radiator Cabinet shows how the cold air is drawn off the floor, warmed and circulated in a continuous, smooth flow by gentle, natural air currents.



HEAT CIRCULATION provides even temperatures from wall to wall and ceiling to floor. Comfortable warmth with no trace of stuffiness. Furniture may be placed close to Trane Convector-radiators, if space is restricted, with no sacrifice in comfort.



COMPACT UNITS which fit snugly against the wall take a minimum of floor space. Full use of all floor area is available because all parts of the room are heated evenly.



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Provincial Notes

(From page 70)

TORONTO — Dr. M. J. McHugh, superintendent of the Toronto Hospital, at Weston, was elected president of the Toronto Hospital Council, succeeding Mr. M. T. Morgan, superintendent of Wellesley Hospital. Vice-president is Mr. W. E. Leonard and secretary-treasurer, Mr. S. W. Martin, both of the Toronto East General.

TORONTO — The Honourable George Doucett, Minister of Public Works for Ontario has announced that it is the intention of the Government to build a new hospital for feeble-minded patients this year. It will probably contain about 1,000 beds and cost in the neighbourhood of $3,000,000. The site has not yet been made known.

WINCHESTER — Ways and means of raising $75,000, the estimated cost of a 20-bed hospital, are being considered by the people of Winchester. A preliminary subscription campaign in the village realized $15,000.

Manitoba

BOISSEVAIN — It is proposed to build a memorial cottage hospital of at least ten beds. The money will be raised by voluntary subscriptions. Assurances have been received from the provincial Department of Health that a health centre will be opened there when the hospital is completed.

BRANDON — The need for an extension to the Brandon General Hospital was discussed by the governors of the institution at their annual meeting in April. While the hospital is designated as a 175-bed institution, there are at present 200 beds in use. Under the Manitoba health plan, Brandon has been designated as one of the three major health centres in the province.

WINNIPEG — A refresher course in nursing technique for practical nurses was opened by the Department of Health in the class rooms of St. Joseph's Hospital. The classes are being held in the evening and will continue for ten weeks. The course is open to all practical nurses and to practical nurses who, following application for licensure, have been advised that a refresher course is necessary to complete their qualifications.

Since the passing of the Practical Nurses' Act, March 1945, which provided for the licensing of women engaged in this type of nursing, a standard of training and experience has been set by a curriculum committee. Applications are being received from existing groups of practical nurses up to and including December 31st, 1946. Licenses have been granted to nurses on the basis of experience, references, etc., but after the above date no nurse will be granted a license unless she has received the minimum training approved by the Department.

Saskatchewan

CANORA — At a meeting of the Board of the Canora Union Hospital, held recently, it was decided that a fifty-bed extension to the present hospital would be built this year.

RADVILLE — A committee will raise funds for a hospital which will serve the town of Radville and the rural municipalities of Lake Alma, Sunrise Valley, Lomond, and The Gap. The committee has in mind a 20 to 25-bed hospital, to cost about $50,000, which would be run by a religious order. The hospital will operate as part of the Weyburn health unit.

SHELLBROOK — A Co-operative Association has been organized in this village to sell shares at $10.00 each to finance a 10-bed hospital. The old town hall will be remodelled for this purpose according to plans suggested by the Department of Health.

Alberta

CALGARY — The current Community Chest and Red Cross drive in Calgary will provide a contribution of $60,000 toward the construction of a new 40-bed Salvation Army maternity hospital. It is estimated that the building will cost $175,000 without equipment. It will be built just south of the present hospital which will then be used as a nurses' residence and home for unmarried mothers.

The same fund will provide $62,500 toward the construction of the four-storey Junior Red Cross Crippled Children's Hospital. The total cost is estimated at $635,000.

CALGARY — Two new motion picture projectors, sound equipment and a screen, purchased with a $1,000 bequest of the late Lt.-Col. J. H. Woods, were presented recently for the use of patients at the Central Alberta Sanatorium.

EDMONTON — The City Council of Edmonton has approved the construction of a 50-bed annex at the Royal Alexandra Hospital at an estimated price of $237,912. The annex will be used for aged patients who need special nursing care and will aid in relieving the congestion which has been prevalent in city hospitals for the past two years.

LETHBRIDGE — The Galt Hospital Board has appointed Miss Orma Smith as superintendent of nurses to succeed Mrs. Bertha Kipp.

British Columbia

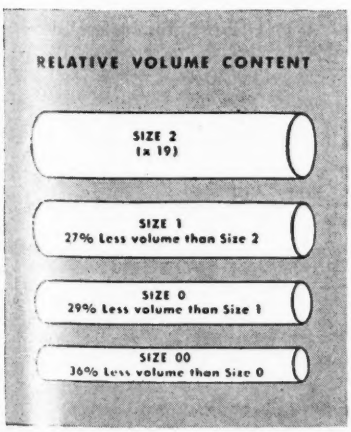
GRAND FORKS — With the assistance of the Provincial Government the Grand Forks Hospital building is being purchased by the town for the sum of $25,000 from Dr. Kingston who will return $3,000 as a donation. The remodelled hospital will provide first class accommodation for 25 adults and 4 children.

VANCOUVER — At the annual meeting of the Crippled Children's Hospital Society, held recently, the institution was officially re-named The Children's Hospital and its scope enlarged to include the treatment of any child in need of prolonged medical care. Construction of the proposed new wing at the Crippled Children's Hospital in Vancouver will give a new lease on life to an estimated 500 spastic children in British Columbia.

New Achievements from Ethicon's Laboratories

Knot breakage further minimized

Suture strength is most essential to the surgeon when the knot is being tied. This is the time of greatest strain. Ethicon's increased strength will aid in further reducing knot breakage.



The above chart shows possible reduction in amounts of suture material embedded in tissue when smaller sizes are used.

• Here are 3 new contributions to surgical technique:

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2. Foreign body reaction reduced. Many surgeons will find smaller sizes adequate.

3. Catgut now usable in many new situations, with the smallest sizes ever made (6-0 and 5-0).

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New, exclusive processes developed by the Ethicon Laboratories have resulted in increases in tensile strength as high as 25% greater than any other catgut suture meeting U.S.P. diameter specifications. Surgeons whose technique makes maximum demands on a suture's strength will have less breakage with the new, stronger Ethicon strands.

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Smaller sizes of catgut retain their integrity longer than larger sizes. The larger the suture, the greater the increase in phagocytosis and enzymatic digestion. The smaller sizes arouse decidedly less foreign-body reaction, hence they maintain their integrity longer.

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These new sutures have received extensive clinical tests by leading surgical specialists. They are expected to be particularly useful in gastro-intestinal, eye, neuro, plastic and infant surgery.

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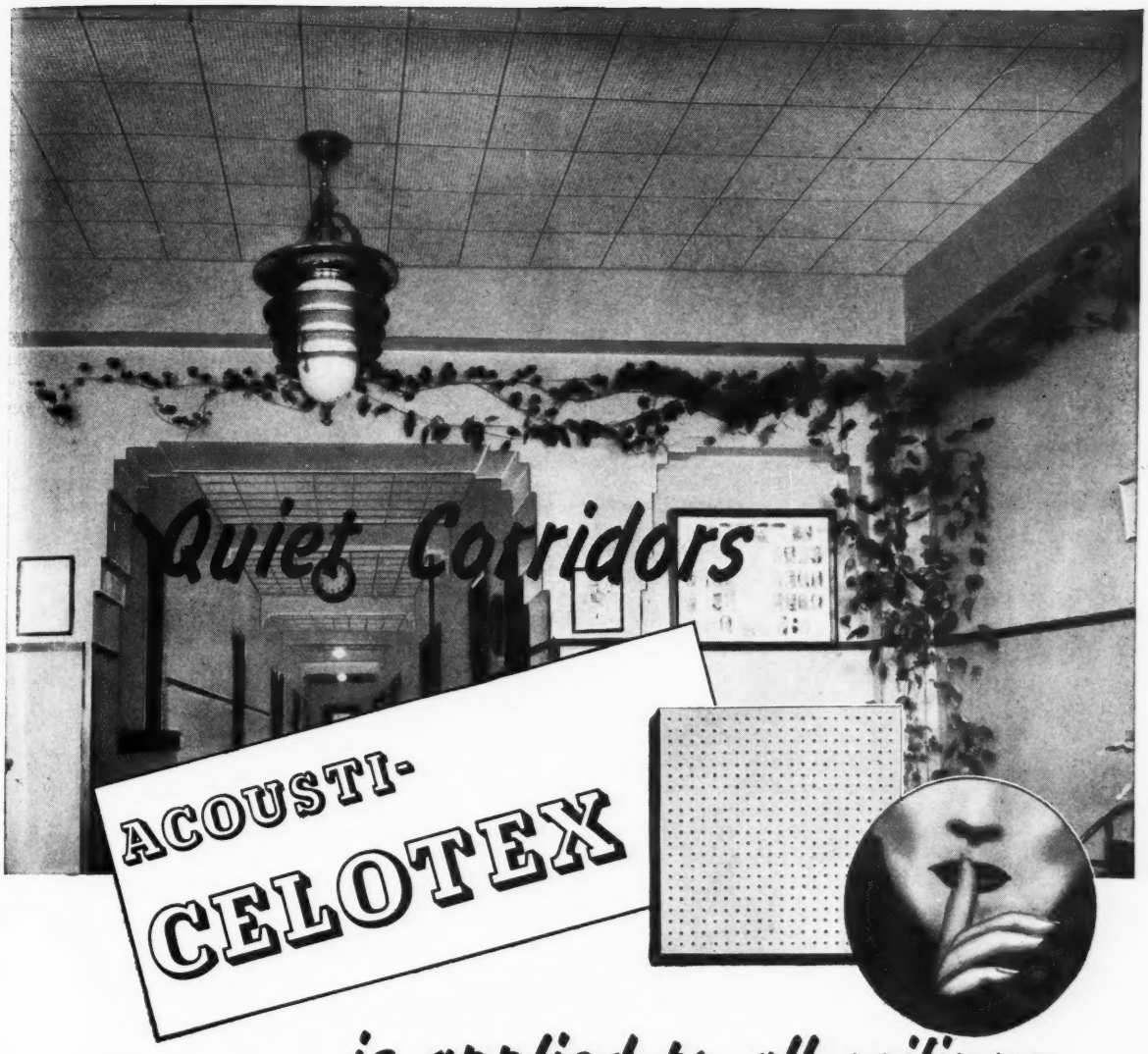

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With Hospitals in Britain

(Concluded from page 50)

Nevertheless, while thousands of divorce actions are pending, Lord Geddes had general support for his contention that marriage should be a serious business, only to be undertaken by those who are prepared to give thought to their suitability to each other, that its purpose is definitely the continuance of the race and that their contribution, in order to be effective, must be made in a satisfactory environment. It is to this national problem that the Pioneer Health Centre has made such a great contribution by providing conditions under which there is opportunity for the adolescent to find a suitable mate, healthy in body, soul and spirit, to aid them in a union which shall be productive of a normal happy fruition and, by contributing conditions of a social environment, to develop the family life for parents and children in a happy home. As Lord Geddes justly claimed, the Pioneer Health Centre, by patient research, has defined the elements of positive health.

The Hon. Ewen Montague, K.C. who took a leading part in the initiation of the Centre twenty-one years ago, announced that the work has now reached a further stage. The Centre will be responsible for the continuance of research and the training of workers for centres in other parts of the country. For this purpose the undertaking passes from a local pioneering effort to a National Trust for the promotion and study of health. In order that it may have adequate financial support steps are being taken, even under present difficult conditions, to raise the sum of $1,250,000. As much of the work which has been done in the Centre has been an inspiration to other countries, it is hoped that some assistance may come from overseas. In the course of the proceedings it was pointed out that national health services do not really become concerned with people until they are sick in bed. Calculations are made of the number of doctors and beds required per thousand of the population, but this Centre has presented a nobler ideal of aiding people to be and remain healthy, by showing that prevention is better than cure and that the soul and spirit have a powerful influence in the maintenance of a healthy body.

Newfoundland to Have 250-bed Sanatorium

Plans have been completed for the erection of a tuberculosis sanatorium at Corner Brook, Newfoundland. The building will accommodate 250 patients and the Government has allocated $1,750,000 toward the project. In view of the difficulty of obtaining building materials and hospital equipment, it is thought probable that the sanatorium may not be completed before some time in 1948.

New Red Cross Hospital in Far North

Construction of a $200,000 hospital at Yellowknife is being planned with a view to its completion in 1947. This will be a 40-bed hospital, built and operated by the Red Cross, the funds to be supplied by the Yellowknife District, which has received assurance that one third of the cost of the building will be covered by the Northwest Territories Council.

Dr. Dunham to O.M.A.

Dr. Harry Stewart Dunham has been appointed Assistant Secretary of the Ontario Medical Association, effective April 1st.

Dr. Dunham was born in Hamilton and was graduated in medicine at the University of Toronto in 1935. After interning at the Hamilton General Hospital he carried on private practice at Arthur, Ontario, and in Hamilton and was on the medical staff of the General Hospital of that city.

In 1942 Dr. Dunham joined the medical branch of the R.C.A.F., where he rose to the rank of Wing Commander. He returned from overseas in March 1946 and was demobilized a few days prior to assuming his new duties with the Ontario Medical Association.

During his period of practice he was an active member of the Hamilton Academy of Medicine and, as a representative of the Committee on Inter-Relations of the O.M.A., he became actively interested in the affairs of organized medicine—an interest which was maintained during his military service.

The present Secretary, Dr. Arthur D. Kelly, who has been in the R.C.A.F. for several years, has been named Assistant Secretary of the Canadian Medical Association and will shortly devote all of his time to the national position.

Research in Rheumatic Diseases

The Hon. Brooke Claxton announced recently that the associate committee on medical research of the National Research Council is "prepared to consider applications for assistance in studying causes and the prevention or treatment" of arthritis and other rheumatic diseases. Research into medical conditions can best be conducted by hospitals and other institutions actively operating in those fields, Mr. Claxton said.

The Kingston General Hospital has been willed $75,000 from the estate of the late Clare Nelson of New York, the income to be used for research on the origin and cure of cancer.

Coming Conventions

May 31-June 1—Canadian Society of Laboratory Technicians, Royal York, Toronto.
June 10-13—Catholic Hospital Association, Milwaukee.
June 10-14—Canadian Medical Association, Banff Springs Hotel, Banff, Alta.
June 25-27—Maritime Hospital Association, The Pines, Digby, N.S.
June 28-29—Maritime Conference, C.H.A., Yarmouth, N.S.
July 1-4—Canadian Nurses Association, Toronto.
September 9-13—A.C.S. Hospital Congress, Waldorf-Astoria, New York City.
September 28-30—American College of Hospital Administrators, Philadelphia.
September 30-October 4—American Hospital Association, Philadelphia.
October 21-24—Ontario Hospital Association, Royal York Hotel, Toronto.
October 28-November 2—Institute on Administration and Convention, Manitoba Hospital Association, Winnipeg.
November 5-6—Saskatchewan Hospital Association, Saskatoon.
November 6-8—Associated Hospitals of Alberta, Palliser Hotel, Calgary.
November 12-15—British Columbia Hospitals Association, Vancouver.

Anaesthetic Explosion Hazards

(Concluded from page 56)

A new type of material is a conductive resin which can be applied as a surfacing material about 1/16 of an inch thick over any type of existing base. This material is sufficiently conductive to be effective when underlaid by any type of metallic strips or gridded conductive material. The experience of munitions plants with this material indicates that it is sufficiently durable to withstand any traffic wear it is likely to be subjected to in the hospital. It has not yet had sufficient use in hospitals to permit a final opinion as to its suitability.

The National Board of Fire Underwriters classifies hospital operating rooms and delivery rooms as "hazardous locations." The Underwriters Laboratories examine various appliances and materials as to their safety for use in such hazardous locations. Of the floor materials noted above only one make of conductive rubber and the conductive resin are classified as being sufficiently conductive to remove the danger of accumulation of static electricity.

But the use of a conductive floor material brings with it an increased danger of shock from the current in the usual electric circuits comparable to handling a "hot" connection while standing on a wet surface. Protection from this hazard may be secured by isolation of the conductive floor from connection with any other conductor except a specially installed resistance which has sufficient conductivity to permit the passage of static electricity but not sufficient to permit the passage of electric current in intensities sufficient to cause a dangerous shock. Another method is the installation of a floor material sufficiently conductive to permit the constant flow away of static electricity but sufficiently resistive to prevent shock from contact with a power circuit.

For several years it was believed that air conditioning of the operating room with the maintenance of a relative humidity of 65 per cent would result in a film of moisture on the surface of objects within the room with sufficient conductivity to prevent the accumulation of dangerous static charges. But a disastrous explosion in an operating room led to an investigation which developed the fact that this method could not be the only one relied upon, though it still remains an important factor.

Cigarette Causes Fire

A small fire in the laundry chute in the east wing of St. Joseph's Hospital in Toronto resulted in the loss of a dozen bed sheets. A smouldering cigarette butt wrapped in the sheets is believed to have caused the blaze.

Panel Heating

(Concluded from page 45)

ing development to be tried yet is the combination of reverse refrigeration supply of heat with panel heating and incidental summer cooling. The low water temperatures for heating which are a criterion of a good heating panel, do permit so high a factor of utilization of the reversed refrigeration cycle, that under favourable conditions, electric heating could be rendered cheaper than heating with more common fuels. The advantages of such an installation would be indisputable.

Osteopaths Score

(Concluded from page 54)

a certain amount of Federal recognition for the osteopaths, and represents a considerable advance in their status under the U. S. Employees Compensation Act. In that act, the term "physician" is defined to include "osteopathic practitioners within the scope of their practice as defined by state law". But H. R. 4717 is free of any such limitations.

The score to date seems to be several runs, several hits and no errors, favouring the osteopaths. What M.D.'s can and will do when they get their innings is still to be answered. In general M.D.'s ignore the osteopaths while osteopaths actively criticize the M.D.'s. The cultists point out in their literature to the laity, for instance, that "non-osteopathic physicians are not trained to discover and correct structural abnormalities" and that "the ordinary M.D. seeks merely to relieve pain while the osteopath gets at the root of the disorder by correcting the basic anomaly".

Whether more basic science laws would help is a moot point. Some physicians urge them on the thesis that the average osteopath cannot pass such an examination and thus would be barred from practice. Others point out that of 1,438 osteopaths who took basic science examinations in seventeen states in a several-year period up to 1944, some 57 per cent passed them; this, they say, indicates that basic science laws may actually serve as a route whereby more than half the osteopaths could get into full practice by the back door.

The suggestion that osteopaths be met with their own weapon of high-pressure promotion and publicity is usually rejected as beneath the dignity of the profession. More acceptable is the educational campaign directed at legislators with a view towards revoking the wide privileges now enjoyed by osteopaths or blocking further extensions of their activities. Medical men to date have had an uneven record of success in influencing legislators. But the legislative know-how can be learned, as some state medical societies have demonstrated.

—William H. Morrison, M.D., in "Medical Economics", Feb. '46.

The important thing is to make the lesson of each case tell on your education. The value of experience is not in seeing much, but in seeing wisely. *—Osler*

Medical Record Librarians

(Concluded from page 40)

health insurance requirements of the future, still more accurate, records may be necessary. As more interns are accepted in teaching hospitals, other hospitals are finding it increasingly difficult to get any interns at all. Much of the work which would normally be undertaken by interns is now being done—and done very well—by others. Specially trained nurses are doing many clinical procedures on the wards; laboratory technicians are draining blood and performing other bedside laboratory procedures; and medical histories, up to the point of the physical examination, are being written by medical record librarians. Some of you in non-teaching hospitals may be doing that now. In some hospitals these histories are being written by ward secretaries or by specially selected graduate nurses, who also take the dictation respecting the physical findings and, later, the progress notes.

In view of this development and the likelihood that this practice may become much more widespread in the 85-90 per cent of our hospitals which can never get interns, it would seem advisable that thought be given to the inclusion of instruction in history writing in some at least of the extension or refresher courses planned for medical record librarians.

This cannot be taught in a few lectures; in fact, many of our best clinicians feel that the taking of clinical histories can only be done by one who has had medical training. This is not the place to debate that question. It is true, however, that for the vast majority of hospitals without interns and with busy medical staffs, the alternative is either to have the history written by such a non-medical assistant, or to have clinical records made up largely of nice blank paper graced only by the patient's name at the top. A history written by the medical record librarian or the ward secretary may not elicit some of the finer points essential to an intricate diagnosis, but with experience and a conscientious and intelligent application to the work, such a person should be able to record a most valuable case history, the dictation of the physical findings being left for the doctor.

Extension or refresher courses might also give instruction on the *Medico-legal* aspects of clinical records. Those of you who are active in association work and those who follow the literature are fully familiar in all probability with this subject, but from many letters of enquiries received over the year, it would seem that some librarians, not to mention the administrator and the medical staff, are still somewhat uncertain respecting the legal status of records.

In conclusion may I congratulate the Canadian Association of Medical Record Librarians on the excellent work which it has done in developing the science and art of medical recording in Canada and to tell you how much your work is valued by the Canadian Hospital Council.

Happy the man whose wish and care
A few paternal acres bound—
Content to breathe his native air
In his own ground.

—*Pope.*

N.S. Government Employees Enrolled in Blue Cross

In April the Honourable F. R. Davis, Minister of Health for the Province of Nova Scotia, announced that his government was adopting and making available to every provincial civil servant Blue Cross health service, with the cost of membership borne by the government.

The Honourable Dr. Davis's announcement is unique and history making. The State of Rhode Island is the only other state or provincial government on the North American continent to provide a similar protection for its employees.

In this, Dr. Davis recognizes the fine co-operation and splendid services which have always been forthcoming from the voluntary hospital system of the province. Through the adoption of this non-profit service, sponsored by the hospitals of the Maritimes, the Government of Nova Scotia has expressed its approval of the Maritime program and has indicated its faith in the ability of the voluntary system to serve the health needs of the people.

This action of the Nova Scotia Government is an example which may well be considered and followed by business and governmental authorities throughout the country.

Joint Medical Setup Proposed for Services

Major-General Charles Fenwick, former Director-General of Medical Services of the R.C.A.M.C., speaking at a farewell dinner tendered him on his retirement from military service, urged that a combined medical force for the three Canadian armed services be set up, and that opportunities be given for medical officers to continue as medical men and not become mere administrators of health work. He pointed out that while before the Second World War medical officers in the permanent forces of both the British and the American armies had opportunity to become specialists, in the Canadian army before 1939 a medical officer's duties were mostly administrative, and sick personnel were necessarily attended either in veterans' or civilian hospitals.

He stated that medical officers of all three services with whom he had discussed these proposals agreed that a combined corps would do away with the present triplication of administrative work and permit men to be assigned by the corps to the service in which they were most interested.

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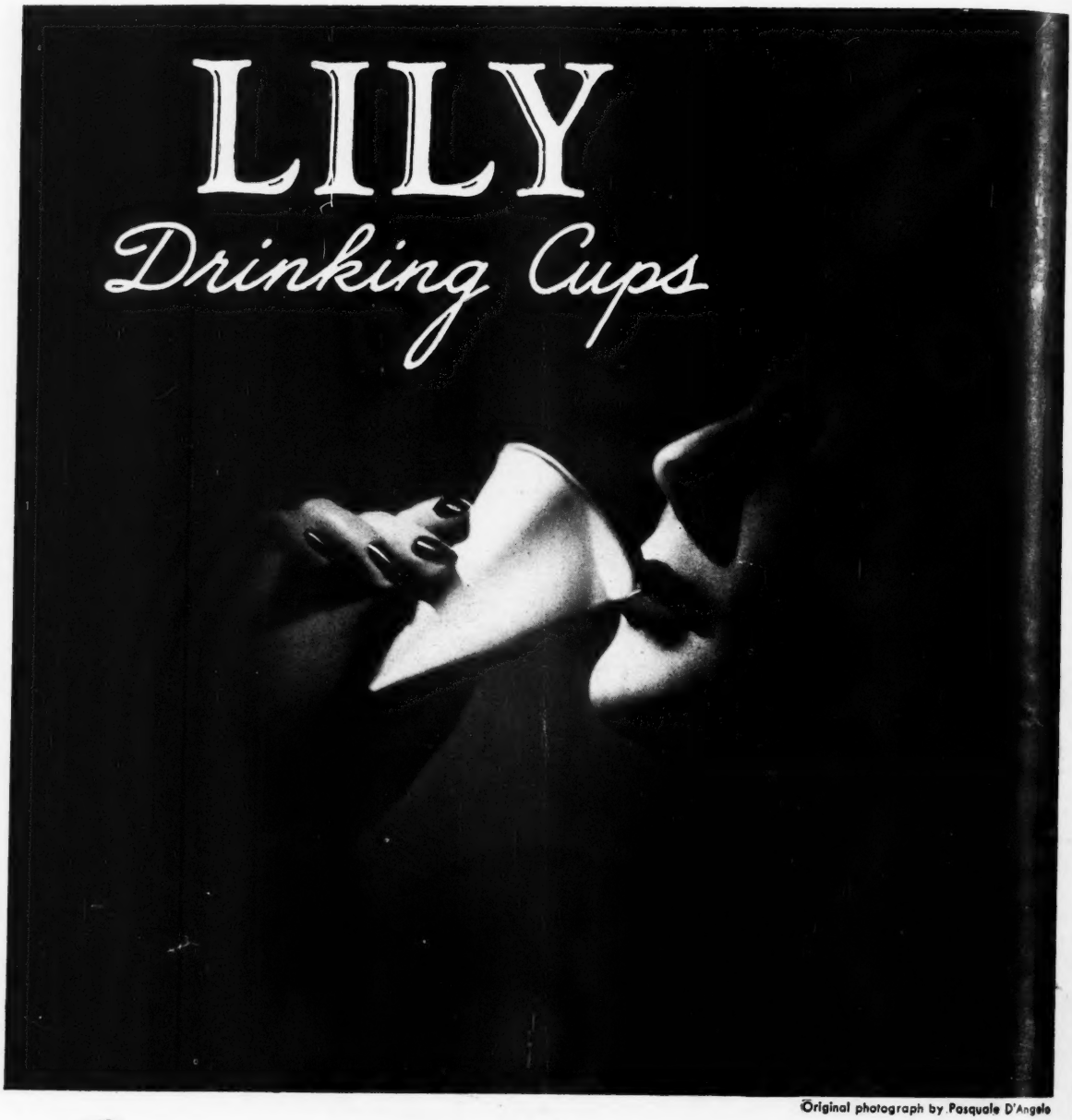

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